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Policy Guidelines on Individual Program Planning for People with Developmental Handicaps

POLICY GUIDELINES ON

INDIVIDUAL PROGRAM PLANNING

FOR PEOPLE WITH DEVELOPMENTAL HANDICAPS

PREFACE

This paper presents final policy guidelines on individual program planning for people with developmental handicaps. The policy guidelines are based on a consultation paper, **Individual Program Planning for Developmentally Handicapped People, Proposed Standards and Guidelines.** The consultation paper was distributed widely in Spring 1983 to service-providing agencies, organizations and interested individuals involved with people with developmental handicaps. Public meetings were held across the province to discuss the proposals and approximately 80 written briefs were submitted to the Ministry.

The revised **Policy Guidelines on Individual Program Planning** reflect the widespread support for the approach to individual program planning and respond to the issues and concerns raised in the consultation process.

To all those who have taken part in the process of developing the policy guidelines, as members of committees, as participants in the consultation meetings, or by submitting written responses to the proposals, the Ministry wishes to express its appreciation and gratitude. The contributions from people in the developmental services field were of great assistance in determining the final guidelines.

Policy Guidelines on Individual Program Planning for People with Developmental Handicaps is also available in French. Additional copies of the document in English or French may be obtained from local offices of the Ministry of Community and Social Services, from the Ontario Government Bookstore, 880 Bay St., Toronto, Ontario, or by writing to:

Services for Developmentally Handicapped People
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1. PLANNING FOR PEOPLE WITH DEVELOPMENTAL HANDICAPS

In this paper, the Ministry presents **Policy Guidelines on Individual Program Planning for People with Developmental Handicaps.** The policy guidelines affect those programs and services funded under the Homes for Retarded Persons Act, the Developmental Services Act and the Vocational Rehabilitation Services Act.

The guidelines are intended to encourage coordinated planning to meet the needs of individuals with developmental handicaps. They describe generally accepted practices based on the experience of the last decade both in Ontario and elsewhere.

Individual program planning emphasizes the participation of people with developmental handicaps and their families in the planning process. The guidelines should, therefore, be of interest to handicapped individuals and their parents, as well as to staff of service providing agencies, professionals and groups working with handicapped people.

This chapter begins with a brief definition of individual program planning, followed by a description of the development of the guidelines. The concluding section presents a discussion of issues in the implementation of the guidelines.

Individual Program Planning

Individual program planning is a process of setting goals for individuals with special needs and defining steps for achieving these goals. The approach is based on the premise that, given appropriate opportunities, each individual is capable of change and positive growth throughout his or her life.

In the planning process, the developmentally handicapped individual, his or her family and key service providers work together to ensure that the individual's needs are met. Working as a team, they begin a careful consideration of all aspects of the individual's development and environmental circumstances. The team selects overall goals and specific objectives, decides on methods to achieve them, and designates responsibility and target dates. The team's decisions are clearly and concisely recorded in a written plan of action: the individual program plan.

Individual program planning can be a powerful tool for improving services to individuals with developmental handicaps. Because the process involves the individual in decision-making, the goals selected will be relevant to that person. The planning process promotes continuity and consistency of service. The written plan provides a lasting framework within which services and programs can be assessed.

Ministry Planning Initiatives

The Policy Guidelines on Individual Program Planning were developed by a provincial advisory committee. This committee, established in the fall of 1983, was given responsibility for:

- finalizing Ministry policy on individual program planning and producing a policy statement and guidelines for use in Ministry-funded services.
- planning, monitoring and evaluating pilot training projects in individual program planning.

The guidelines themselves, however, represent the result of a developmental process spanning several years. The process has included systematic research and public consultation. It has involved Ministry policy and operational staff, representatives of community agencies, and developmentally handicapped individuals and their families.

The process formally began in 1975 when the Ministry of Community and Social Services adopted a five-year plan for services for people with developmental handicaps. The plan included detailed proposals for the development of community-based services and proposed that an individual program plan be developed for every client of Ministry-funded services.

In the years between 1975 and 1980, community-based services expanded dramatically. During the same period, individual program planning was introduced in Ministry-operated facilities as a means of assisting clients to move from institutions to community programs. The individual program planning approach was also encouraged in community programs. Establishment of individual program planning for all clients proved, however, to be more complex than originally anticipated.

In 1980, the Ministry set up the Task Force on Individual Program Planning. In its 1981 report, the Task Force noted a number of problems including a wide variation in interpretation of the individual program planning concept, poor service coordination, a lack of training for personnel and assessments that were not used effectively in planning for clients.

Several research projects were undertaken as a result of the Task Force's recommendations. In the spring of 1983, the Ministry published three reports based on these projects:

- **Directory of Assessment Services for Developmentally Handicapped People**
- **Functional Assessment Instruments for Developmentally Handicapped People**
- **Individual Program Planning for Developmentally Handicapped People: Proposed Standards and Guidelines**

This last report presented proposals for the standardization of the individual program planning process.

Public Consultation

Between May and July 1983, the Ministry conducted a public consultation on its proposals on individual program planning. The purpose of the consultation process was to get direct, concrete feedback to see if the proposed Standards and Guidelines were workable.

It is estimated that approximately 1,000 people participated in information meetings held in communities throughout Ontario. A wide range of agencies, interested groups and individuals submitted over 80 written briefs in response to the proposals.

Response to the consultation paper indicated that overall, people supported the Ministry's approach to individual program planning. Consultation feedback suggested that individual program planning is recognized as benefitting clients as well as agencies working in the developmental services field. Many issues and concerns were, however, raised during the public meetings and in the written responses submitted to the Ministry. The feedback indicated that:

- o there is a need for staff training in individual program planning
- o local, area and regional needs must be recognized
- o the final individual program planning policy must reflect the concerns of service providers.

Ministry's Response to Consultation

In the fall of 1983, the Ministry undertook a revision of the **Proposed Standards and Guidelines**. The provincial advisory committee began the revision with a careful review of the consultation feedback, identifying major issues to be addressed. Issues of concern to most consultation participants included:

- o the role of the individual program plan coordinator
- o the composition and formation of the individual program plan team
- o client participation in individual program planning
- o time frames for plan development and review
- o Ministry support to service-providing agencies, to assist them with meeting the proposed standards.

In addition to these major concerns, other issues and detailed suggestions arising from the consultation were reviewed.

At the same time, pilot projects to train staff of service providing agencies in individual program planning were initiated. The projects tested a curriculum developed to train staff in individual program planning. The curriculum was aimed primarily at front-line staff, although handicapped persons, their parents, agency administrators, board members and Ministry staff also participated. The training included both in-class and on-site instruction.

The training projects were intended to accomplish a number of purposes:

- o provide staff of community agencies with an understanding of the philosophy and techniques of individual program planning
- o clarify for service providers the Ministry's expectations in regard to individual program planning
- o determine what kinds of community resources might be available for future training initiatives.

The training projects were developed through a cooperative effort between local agency representatives and Ministry staff. A local committee was established in each community participating in the pilot training. The local committee was given responsibility for identifying suitable trainers, finding locations for classroom sessions and acting as a liaison between community agencies and the Ministry.

As of June, 1984, nine communities have participated in the pilot training projects. Although formal evaluation has not yet been completed, preliminary feedback suggests the training has been worthwhile. Informal reports from trainers and local training committees indicate that community agencies continue to be concerned about the major issues raised in the consultation process.

The Guidelines Approach

As a direct result of the feedback from the consultation process, the Ministry has chosen to use a "preferred practices" or guidelines approach for implementing the individual program planning policy.

A number of factors pointed to the advisability of a non-regulatory approach. First of all, individual program planning is a dynamic, interactive process which must be tailored to meet different individual needs and situations. Such processes are difficult to regulate. The introduction of formal standards requires that there be specific criteria against which performance will be measured. Given the variety of programs and settings in which individual program planning is used, these criteria would be difficult to determine with any precision.

Secondly, service providing agencies vary tremendously in the types of services they offer, their staff resources, their administrative structures and their relationships with other service providers. All of these factors are important in the day-to-day process of individual program planning. Given this variation, a set of guidelines outlining preferred practices is more appropriate than detailed standards prescribing how agencies should approach implementation of individual program planning.

Consequently, the implementation of the guidelines will be the responsibility of the individual agency. Those agencies now developing an individual program planning process should find the guidelines of assistance in their design. Agencies that already have planning processes may wish to review them in light of the emphasis on team planning, client and family participation and practices of assessment, monitoring and review.

Monitoring and evaluation systems are useful tools for agencies in assessing the effectiveness of their IPP processes. Agencies that have implemented IPP's may now wish to consider how to evaluate and improve them.

The Ministry will support the objective of effective individual program planning in several ways: co-ordination of training in the IPP process will continue to be provided locally; community colleges will be encouraged to include IPP content in appropriate curricula, and the Ministry will consult with service providers regarding the implementation of the IPP process within their agencies.

Other Policy Approaches to Individual Program Planning

The **Policy Guidelines on Individual Program Planning** represent only one of a number of efforts the Ministry has undertaken to increase the responsiveness of services to individual needs. For example, regulations incorporated under the Children's Residential Services Act include a requirement for the development of an individualized plan of care for each child. Regulations under the Day Nurseries Act require the development of written individual program plans and written individual training/treatment plans for children with developmental and physical handicaps enrolled in day nurseries or supervised private-home day care programs.

Other Ministries, too, are looking at the need for greater individuation in service delivery. For example, the Education Amendment Act (1980), administered by the Ministry of Education, states that school boards are required to provide education programs for all resident pupils within the jurisdiction. By September 1985, the education of pupils with developmental handicaps presently enrolled in programs licenced under the Day Nurseries Act, as well as those presently being served by an educational program, will be the responsibility of school boards.

The Act states that exceptional students are to be given access to an "appropriate educational program". The legislation requires school boards to have a placement plan for each pupil. This plan is to be reviewed annually.

2. THE PHILOSOPHY BEHIND INDIVIDUAL PROGRAM PLANNING

Goal of the Policy Guidelines on Individual Program Planning

The goal of the policy guidelines on individual program planning is to encourage a coordinated approach to planning services, supports, and programs appropriate to the needs of individuals with developmental handicaps. Improved individual program planning aims at assisting people with developmental handicaps to acquire the skills, habits and attitudes essential to living in present-day society.

Principles

The philosophical principles underlying the proposals on individual program planning were affirmed by participants in the consultation process. This section repeats, for the most part, the discussion of principles which appeared in the consultation paper. Two significant changes have, however, been made. First, with the decision to implement a supportive, educative policy on individual program planning rather than a regulatory one, the principles of agency accountability and evaluation have been removed from the guidelines document. The Ministry remains concerned about these principles and will continue to address these issues in other policy documents. Second, the definition of the normalization principle has been changed, to reflect the way the concept is now understood in the developmental services field.

1. Normalization: Restoration and/or maintenance of a valued social status for persons with developmental handicaps are central to the process of normalization. Individuals with developmental handicaps whose place in society is valued and integrated will experience activities that are appropriate to their age and culture, that protect their personal integrity while allowing them the dignity of risk that accompanies normal living.

2. Developmental Model: The planning process should provide a systematic framework for positive change based on the assumption that all persons are capable of development and learning.

3. Client Participation in Decision Making: Programs should provide for the active participation, to the fullest extent possible, of the client and, as appropriate, of the client's family or guardian and/or representative in the service provided.

The implications of these principles for individual programs planning are discussed below.

Normalization

Normalization has been defined as the "use of culturally normative means" to offer persons with developmental handicaps "life conditions at least as good as (those) of average citizens and to as much as possible enhance or support their behaviour, appearances, experiences, status and reputation".(1) All individual program planning practices and procedures for individuals with developmental handicaps should reflect consideration of the normalization principle, to help establish patterns and conditions of everyday life that are as close as possible to the regular circumstances and ways of society.

As elaborated by Bengt Nirje,(2) this implies normal patterns in all activities:

- daily routines for getting up and getting dressed, involvement in meaningful activities, eating and retiring in normal circumstances
- weekly routines with the differentiated settings, schedules and activities of home, school/work and leisure
- the observance of annual holidays, days of personal significance and vacations
- normal experiences of the life cycle that progress from early childhood through school age and adulthood to old age
- respect and consideration for the wishes and choices of the person as well as his or her right to self-determination
- life in a social world that includes friendships, dating and marriage
- normal economic standards through access to financial assistance and sheltered or competitive employment
- environments where all activities are modelled on those available to the mainstream of society.

The anticipated effect of normalization is not to make people with handicaps "normal"; rather, it is to improve the quality of their lives. When properly implemented, normalization positively affects developmentally handicapped persons' quality of life, not as a "treatment" given them, but as a foundation for planning, delivering and evaluating human services.

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1. Wolfensberger, 1980.
2. Nirje, 1980.

A corollary of normalization is the desirability of meeting the individual's developmental and service needs through the most integrative service alternative. Integration occurs at several levels: physical, functional, personal, social, societal, and organizational. Where the available alternatives are restrictive, efforts should be made to develop and/or support more integrative alternatives.

The Developmental Model

Program models in human services are characterized by distinctly different perspectives on overall program goals, the role of the recipient of service and the nature of his or her relationships. The models are reflected in functional philosophy, methods and terminology used, physical and administrative structures, and job descriptions.

The developmental model provides the most desirable framework or set of ideas to support programs for persons with developmental handicaps. It assumes that all persons are capable of growth, development and learning, and suggests a positive interpretation of developmental handicaps and programming.

- Every person is considered to have some potential for development, and efforts to maximize the person's potential should not be abandoned although progress may be limited.
- The handicap is viewed as functional; a medical condition, once stabilized, is of secondary concern.
- Functional assessment is favoured over diagnostic assessment as the basis for programming.
- The helping relationship is one of consulting, training and teaching aimed at fostering self-reliance and maximizing potential.
- Residential services are patterned on and aimed at normal life experiences.(3)

This program model is based on three core concepts:

1. Change as a characteristic of life: From the moment of conception, the most outstanding characteristic of life is that it changes, both physiologically and psychologically, and continues to do so throughout the life span of every human being.

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3. See Roos, 1971.

2. Movement from simple to complex skills: The life long change characteristic of all human beings progresses in a predictable, orderly sequence that can be identified, and is seen as moving onward from simple skills that become the foundation for more complex skills or behaviours.

3. Individual rate of development: Movement through developmental sequences is variable, influenced by individual and cultural differences. The rate and direction of an individual's development may be significantly altered by manipulating physical and psycho-social variables in the environment. The potential for development is realized in an environment that provides suitable opportunity and support.

Thus the developmental model suggests that persons with developmental handicaps are more "like" than "unlike" non-handicapped persons, and rejects the notion that differences are qualitative.(4)

Although the developmental model holds positive implications, it is susceptible to misuse or misinterpretation. Developmental "model" is sometimes equated with "sequence", resulting in possible negative effects for the handicapped individual.

Sequences of development are not inviolable, as witnessed by the variability in any random group of children. The rate of progress through a sequence varies among children and even for the individual child. There can be a tendency, however, to use sequences in a developmental assessment or curriculum in a lockstep or rigid and simplistic fashion.

Decisions regarding program goals ought to be governed by the developmental model, not the developmental sequence. The developmental model prescribes goals that influence the rate and direction of change. The criteria used in selecting the rate and direction of change ought to be derived from those aspects of human living that are most valued and adaptive. The decision-making process should encompass the following broad goals:

1. Increased ability to cope with the environment: Coping implies the ability to have some control, for example by making choices. Control begins with having input into decisions made about one's life, and extends to learning specific skills in and for specific environments. Change should be in the direction of skills that are age-appropriate and needed for success, as defined by current and future roles and cultural expectations.

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4. Ziegler, 1969.

2. Increased complexity of behaviour: Effective adaptation to a complex environment requires complex patterns of behaviour, which emerge from the integration of more simple abilities and activities. Prerequisite skills for more advanced behaviour must be taught in an environment that supports and provides opportunities for the inter-relation of ideas, emotions and skills.

3. Maximization of human qualities: The maximization of human qualities that are valued becomes perhaps the most basic criterion for choosing program goals. Human qualities are those attributes that describe the essential nature of man, and include loving, curiosity, spontaneity, initiative and enthusiasm.

Developmental programming will be characterized by the expectation of positive change, individualization and positive, helping relationships in an appropriate environment and grouping. The developmental goals for persons with or without a handicap are essentially the same.

Client Participation in Decision Making

This principle was discussed in detail in many of the consultation meetings. While the principle of client participation to the fullest extent possible received general support, concerns were raised regarding the practicality of clients attending team meetings.

Clients' potential to participate in planning their own programs should be recognized and developed. The Ministry realizes, however, that some individual clients may not be able to participate as full team members -- when the client has a severe handicap, for example. In such circumstances, other approaches may be used. For example, the client could attend briefly at the beginning of team meetings or the team could visit the client in the client's usual setting. The team is encouraged to work towards increasing the client's participation in future meetings.

The principle of client participation raises the question of the language of service provision. The Ministry is committed to providing its services in the French language in areas where there are significant concentrations of francophones. In keeping with the Ontario Government's policy on French Language Services, the Ministry encourages service providers to make services and programs available in English and/or French, as appropriate to the needs of their clients. For clients whose language is other than English or French, service providers are encouraged to arrange for translation services to be available during the individual program planning process.

Incorporating the principle of client participation into the individual program plan for a person with a developmental handicap respects that person's individual worth, and acknowledges the good judgement of the client and/or family/representative with regard to determining the client's needs and how they may best be met. Implementation of this principle is also a means of increasing clients' ability to assume the maximum possible control over and responsibility for decisions and events in their own lives. The principle stresses their strengths in terms of what they can do for themselves. Also, direct involvement in the planning and carrying out of the individual program plan enables the client to better understand the expectations and to see the effects of the plan.

In this approach, client, family and staff have a shared understanding of and sense of responsibility for the program, and participate as equal members of a team. The key decision points in the individual program planning process that call for client/family/representative participation include:

- o assessment of strengths and areas where development and positive change are possible and desirable
- o specification and priorization of goals and methods
- o review of progress
- o modification or termination of the plan.

As this decision-making process proceeds, it is essential that clients, and/or their family/representative, participate as much as possible in planning their own program, and that they have access to all information regarding this planning, as a basis for responsible decision making. Clients have the right to retain control over their own lives and the right to full information regarding decisions concerning them.

The capacity of people with developmental handicaps to speak on their own behalf varies, depending on their level of functioning. Some will be able to participate in discussions with explanation and assistance, while others will be completely non-verbal. A client who is an infant or a young child obviously must be represented by a parent or guardian. An adult client who cannot fully or clearly represent his or her own views needs a parent or representative to speak on his or her behalf. This person must be able to empathize with, communicate with, and elicit responses from the client whenever possible. Whatever the client's communicative ability, his or her presence will provide a needed focus for the other team members, and should ensure attention to his or her interests and preferences.

3. HOW TO READ THE GUIDELINES

Guidelines have been developed to cover the entire individual program planning process. The sequence in which the guidelines are presented does not, however, represent a strict chronological order. Some of the process components may be occurring simultaneously. To assist the reader to understand how the different components fit together, the accompanying diagram (page 15) illustrates the individual program planning process.

General Organization

The guidelines appear in Chapters 4 through 10. Each chapter is concerned with a major topic area. Guidelines connected to a major topic are identified by a letter code. The major topics and accompanying letter code are:

- **TG:** the team approach to individual program planning (Chapter 4)
- **AG:** assessments for individual program planning (Chapter 5)
- **DG:** development and content of the individual program plan (Chapter 6)
- **IG:** implementation of the individual program plan (Chapter 7)
- **RG:** review of the individual program plan (Chapter 8)
- **FG:** individual program planning records (Chapter 9)
- **SG:** agency supports for individual program planning (Chapter 10)

The major guideline topics are divided into sub-topics, each of which is assigned a number. An example of an assessment sub-topic is:

- **AG - 01 Role of Assessments**

In this example,

- **AG** is the topic code
- **01** is the sub-topic number
- **Role of Assessments** is the sub-topic title.

Sub-topic numbers run consecutively throughout the major topics. The assessment sub-topic numbers, for example, run consecutively as follows:

- **AG-01 Role of Assessments**
- **AG-02 Identifying Assessment Needs**
- **AG-03 Assessment Referrals**
- **AG-04 Conducting Assessments**
- **AG-05 Synthesis, Reporting and Follow-up**

Within each sub-topic, the guidelines are assigned decimal numbers. For example, the sub-topic **AG-01 Role of Assessments** has two guidelines numbered AG-01.1 and AG-01.2

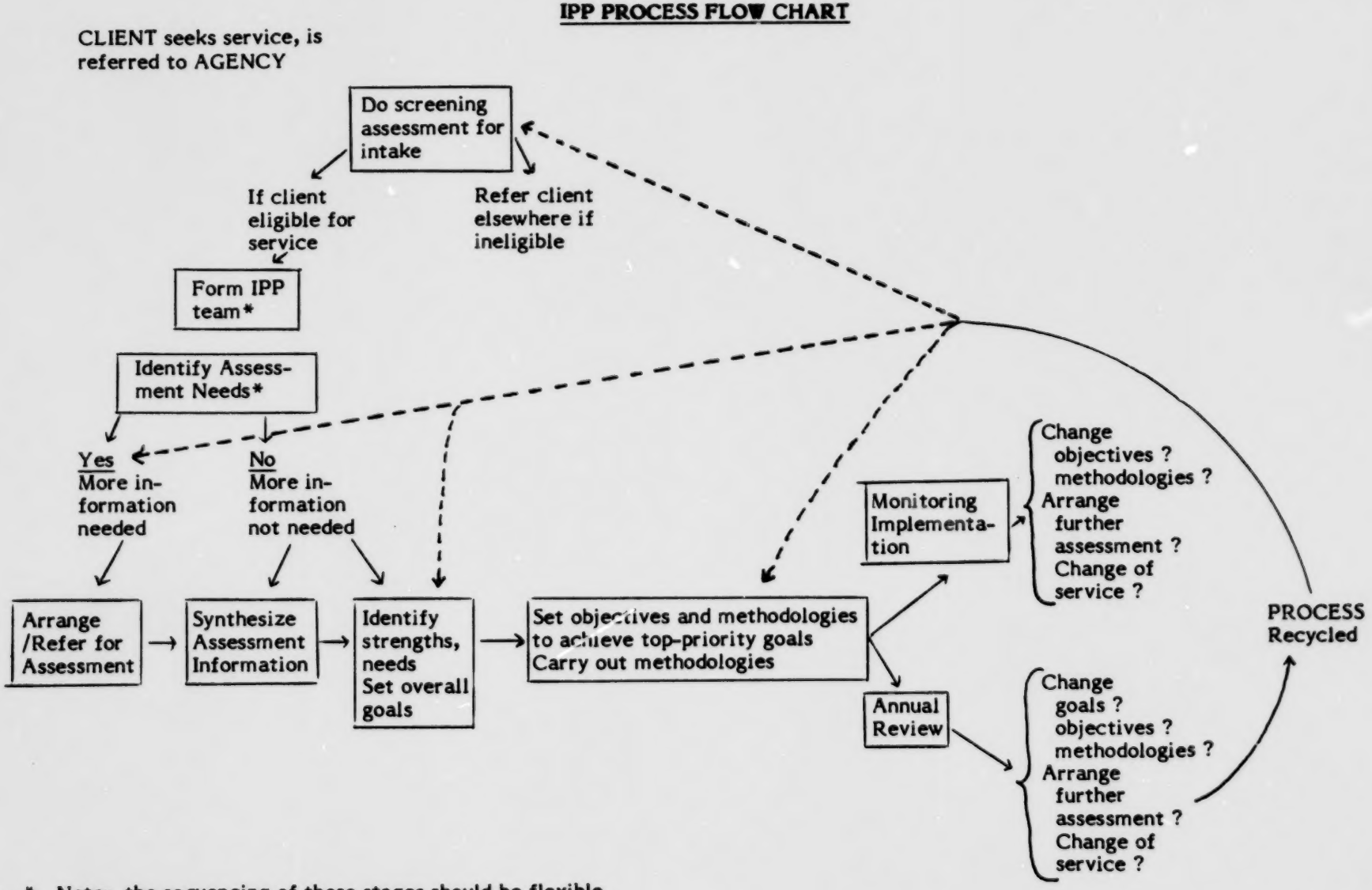
Summary of Individual Program Planning Process

Appendix A, page 68, presents a step-by-step summary of the individual planning process. The guidelines relating to each step of the process are shown, along with brief notes on practical considerations, guiding principles and philosophy, and responsibilities.

Glossary

To assist the reader, a Glossary is presented in Appendix B, page 74.

IPP PROCESS FLOW CHART


CLIENT seeks service, is referred to AGENCY
Do screening assessment for intake
If client eligible for service
Refer client elsewhere if ineligible
Form IPP team*
Identify Assessment Needs*
Yes More information needed
No More information not needed
Arrange /Refer for Assessment
Synthesize Assessment Information
Identify strengths, needs Set overall goals
Set objectives and methodologies to achieve top-priority goals Carry out methodologies
Monitoring Implementation
Change objectives ? methodologies ? Arrange further assessment ? Change of service ?
Annual Review
Change goals ? objectives ? methodologies ? Arrange further assessment ? Change of service ?
PROCESS Recycled

* Note: the sequencing of these stages should be flexible.

4. INDIVIDUAL PROGRAM PLANNING: THE TEAM APPROACH

The Ministry continues to support a team approach to individual program planning as the most effective means of planning to meet individual client needs. The essence of the team approach is the collaboration of the client and one or more service providers in the planning, implementation and review of a single integrated plan. The strength of the team approach lies in the ability of team members to bring distinctive insights and perspectives to the planning process.

The **Proposed Standards and Guidelines** promoted the idea of interdisciplinary teams for individual program planning. In an interdisciplinary approach, persons from various backgrounds work together without the constraints imposed by assigning a particular developmental area to a particular discipline only. Each team member contributes the skills, knowledge and perspectives provided by his or her training. Various viewpoints are represented especially well when persons from different disciplines also represent the different agencies involved.

Agencies, in response to the consultation paper, voiced concern about the emphasis on interdisciplinary teams. Three main issues were identified.

1. Formation of an interdisciplinary team is not possible in many situations. A single agency may be the only service provider involved with the client. Access to resource professionals is limited, particularly in rural and remote areas.

2. Collaboration of all agencies involved with the client cannot be guaranteed. Some service providers may choose not to participate. This may be a particular problem when clients are involved in services operated and/or funded by other Ministries or other levels of government.

3. For individuals whose involvement in the service system is minimal, the formation of an interdisciplinary team may not be necessary.

The Ministry appreciates these concerns. The revised guidelines, while encouraging the formation of interdisciplinary teams, recognize that in some situations, this may not be possible.

The guidelines suggest the concept of a core team. A core team would at minimum consist of the client and a service provider. Other members could be added as appropriate to the unique circumstances of the individual. Additional members could include other people working directly with the client, special consultants, family members or volunteers.

Team Composition

Commentary

The exact composition of an individual program plan team cannot be specified. Rather, the composition of a particular team depends on a number of other factors: the need for service coordination, the availability of other resources, and the wishes of the client.

Effective service delivery requires coordination of resources. Such coordination involves initiating, sustaining, and inter-relating the various parts of the service delivery system. In a variety of documents, the Ministry has identified the importance of coordinated service delivery.

A primary consideration in team composition is, therefore, the need for service coordination. If an individual is receiving services from several agencies, their service approaches should be planned in a coordinated way. Coordinated planning is needed so that:

- gaps in service can be identified and remedied
- overlap of services can be kept to a minimum
- agencies can adopt complementary training and habilitation approaches.

A single agency may, however, be the only service provider involved with the client. The agency may, with the consent of the client, ask specialized resource professionals (physiotherapists, psychologists, speech therapists, etc.) or other resources (volunteers, clergy, relatives, friends, etc.) to participate on the team. If outside resources are not available, the individual program plan team would then be composed of the client (family/representative) and an agency worker.

The team approach to individual program planning emphasizes participation of the client and/or the client's family or representative. In the past, clients and their families were often passive recipients of programs and services, given little opportunity to express their own views. Many community groups, clients and concerned service providers began to ask for greater client involvement in service planning.

The guidelines, therefore, continue to reflect the principle of client participation (See p. 11). They support the idea that clients who are active participants in the planning process derive greater benefits from the services and programs they receive.

The guidelines stress the participation of the developmentally handicapped person aged 16 or older, and the extension of an invitation to attend in the case of the handicapped young person aged 12 or older. This is consistent with the provisions in the standards for children's residential care facilities under Ministry jurisdiction, which require the development of an individual plan of care for each child with the involvement to the maximum extent possible of the child aged 12 or older. Team procedures must encourage and facilitate the participation of the client and/or the client's representative as informed team members.

If the developmentally handicapped client is a child under the age of 16, his or her parent(s) or guardian should be invited to participate as team members.

For an adult client, the involvement of his or her parents or other family member may be invited as appropriate. If the client's family will be directly involved in implementing some portion of the individual program plan, their participation as team members may be desirable.

A child or adult client may also choose a representative to speak on his or her behalf. The representative, who would participate as a team member, would ensure that the client's interests are presented to other team members. The **Proposed Standards and Guidelines** used the term "advocate" for the client's spokesperson. To many service providers, the term suggested a formal, legalistic relationship between the client and the advocate. In response to this feedback, the term "representative" was selected in place of "advocate".

The notion of a representative is broader than that of advocate. It implies someone who assists the client to present his or her views and concerns to the team. The representative could act as an interpreter for the client, could help a client to articulate his or her goals, could act as moral support for the client during team meetings, could attend team meetings on the client's behalf, if the client is unwilling or unable to attend.

Clients should be given the opportunity to select their own representatives. The representative should be someone who takes an on-going, personal interest in the client. He or she could be a friend, a former service provider or a volunteer. A service provider involved professionally with the client would not usually become the client's representative unless requested to do so by the client or unless no other person was available to serve in this capacity.

TG-01 Team Composition

TG-01.1 The individual program plan team should:

a) include the developmentally handicapped client who is 16 years of age or over

b) include as appropriate a developmentally handicapped client who is a child of 12 years of age or over

c) include the parent(s) or the person with legal custody of a developmentally handicapped client who is a child under 16 years of age

d) include as appropriate a family member or a client-selected representative for a client who is an adult

e) include those persons working most directly with the client

f) include persons in the service areas, disciplines or professions relevant to the handicapped person's identified needs and goals.

Forming the Team

Commentary

During the consultation process, service providers asked for guidance on the mechanics of forming an individual program plan team. In response, this section on forming the team has been added to the guidelines.

As a first step in forming a team, the guidelines recommend that each service involved with the client designate a worker responsible for the client's individual program plan. The worker responsible acts as his or her service's representative on an individual program plan team. The worker responsible does not necessarily become the individual program plan coordinator. (Selection of the coordinator is discussed later in this Chapter). Rather, the worker responsible is basically a team member of a particular client's individual program plan.

The worker responsible can be any staff member who knows the client well and who can make an informed contribution to program planning. In some agencies, a front-line worker such as a residential counsellor or vocational instructor could be designated as the worker responsible for a client's individual program plan. In other agencies, a program manager or resource staff (e.g., intake worker or social worker) could be designated.

The worker responsible would explain the purpose of individual program planning to the client and request the client's participation. The worker responsible would also obtain written, informed consent to release information to and obtain information from other agencies involved with the client. Depending on the client's age and capacity to consent, written consent can be obtained from the client, the client's parent(s) or guardian, another family member or the client's representative.

After the designation of a worker responsible, the process of forming a team may take place informally or it may be very formalized, depending on the individual situation. As a general rule, the degree of formality required will depend on the number of services involved with a client and the relationship between those services.

For example, a child with a developmental handicap may be receiving services through a supervised private home care agency. The agency would probably designate the agency home visitor as the worker responsible for the individual program plan. The home visitor, the caregiver and the child's parent could agree to meet to discuss the child's placement and develop an individual program plan. This individual program team could be formed through a relatively informal process.

When one agency provides two or more services to a client or when two or more agencies are involved, a more formal approach to forming the team may be desirable. For example, the steps in a formal process could proceed as follows:

1. Responsibility Designation: Each service involved with the client appoints a worker responsible for the client's individual program plan.

2. Client Consent: The client would be made aware of the designation of a worker responsible for his or her individual program plan. The worker would then explain the individual program planning process to the client, obtaining written permission from the client to contact other agencies and to have access to relevant information on the client.

3. Relevant Contacts: Through discussion with the client, the worker would determine what, if any, other services are involved with the client and identify relevant contact people. Together, the worker and the client would decide which other service providers and resource people were going to be contacted for the purposes of individual program planning.

   When a service is ready to develop an individual program plan for a client, the worker responsible would contact these service providers and resource people. The worker responsible would invite them to participate on the individual program plan team.

4. I.P.P. Team Formed: The composition of the individual program plan team would depend on the response of those invited to join the team. The team would be formed by those service providers and resource professionals who feel that coordinated planning will benefit the client.

This type of formal approach to the process of team formation might be helpful in situations where one agency provides two services to a client -- residential and vocational services for example. Or it could be used when a client receives services from more than one agency (e.g., residential placement through Children's Aid and educational services from an infant development program).

During the consultation process, service providers asked about situations where the client is receiving services from agencies outside the jurisdiction of the Ministry. Such situations are likely to be the norm for school-age children and they may also occur for adult clients.

The guidelines encourage the participation of all service providers involved with the client. A child's school teacher, for example, should be invited to join the individual program plan team. Some service providers may choose, however, not to participate as team members. While their cooperation can be invited, it cannot be compelled.

Finally, while the Ministry strongly encourages a team approach, it recognizes that an individual program plan team is not a fixed entity. The process of team formation is dynamic. Team composition is likely to be flexible, changing as a client's needs and service involvements change.

TG-02 Forming the Team

TG-02.1 Each service involved with a client should designate a worker responsible for individual program planning for the client.

TG-02.2 The worker responsible should obtain written permission to contact other services and/or agencies and to exchange information. Written consent should be obtained from:

a) the client, where the client is sixteen years of age or older and has capacity

b) from the nearest relative (as defined in the Mental Health Act, R.S.O. 1980, ch. 262) where the client is sixteen years of age or older and does not have capacity

c) from the Committee appointed under the Mental Incompetency Act, where the client is 18 years of age or older and has been declared incompetent under the Act.

d) from the client's parent(s) or the person with lawful custody where the client is not yet sixteen years of age.

TG-02.3 Prior to the development of the individual program plan, the worker responsible and the client/family/representative should determine:

a) what other agencies are providing service to the client

b) the names of relevant contact persons in the other agencies

c) which other agencies and/or resource persons the client wishes to participate on the individual program plan team.

TG-02.4 Prior to development of the individual program plan, the worker responsible should contact potential team members to invite participation on the team.

TG-02.5 Within 30 days after a service or agency newly enters into a helping relationship with the client:

a) a worker responsible for the client's individual program plan should be designated

b) the worker responsible should determine if an individual program plan team exists and become a member as appropriate of that team

c) the worker responsible should review an existing individual program plan.

The Individual Program Plan Coordinator: Selection and Responsibilities

Commentary

The consistency and efficiency in the individual program planning process will be enhanced if one team member takes responsibility for overall coordination of the activities of the individual program plan team and for monitoring the development, implementation and review of the plan. This team member is referred to as the individual program plan coordinator.

During the consultation process on the **Proposed Standards and Guidelines**, agencies expressed concern about the role of the individual program plan coordinator. Two major issues were raised:

- the way in which the coordinator would be selected
- the extensiveness of the coordinator's responsibilities.

The revised **Policy Guidelines** respond to these concerns.

First, the guidelines suggest that the individual program plan coordinator be selected by the team. The choice of which team member is to be the individual program plan coordinator will be unique to each setting and will require the cooperation of agencies involved with the client to determine the most logical person. For example, the individual program plan coordinator could be the client's case manager where there is such a person or the coordinator could be another agency worker such as a residential counseller, a family support worker, public health nurse or other service provider working with the client and family. A parent, other family member or other person closely involved with the individual, could serve as coordinator depending on his or her skills and qualifications. If, however, only one service is involved with the client, the worker responsible will become the coordinator. The coordinator role may shift over time as the focus of the individual program plan changes.

Second, responsibilities previously assigned to the coordinator have been modified. Many have been assigned to the team as a whole. The guidelines take the position that the coordinator's responsibilities be defined as:

- convening and coordinating team meetings
- monitoring implementation of the plan
- ensuring that the work of the team is documented
- participating as a team member in the development, implementation and review of the plan.

In convening team meetings, the coordinator would be responsible for scheduling the meetings and notifying all team members as to the time and location. Scheduling is particularly important for ensuring attendance of team members including the developmentally handicapped client and/or family member or representative.

During team meetings, the coordinator would act as chairperson. He or she should ensure that all viewpoints are heard and that necessary decisions are made.

In the implementation phase of the individual program planning process, the coordinator would be responsible for monitoring implementation. The coordinator is encouraged to contact team members regularly. The method and frequency of contact needed will, of course, depend on individual circumstances. If the coordinator becomes aware of difficulties in implementation, he or she can seek advice from other team members or if necessary, work through existing intra- and inter-agency channels.

The guidelines suggest that the coordinator take responsibility for documenting the work of the team. These responsibilities include ensuring that minutes of team meetings are taken and distributed to team members, and ensuring that all team members receive a copy of the individual program plan. The coordinator might also maintain the individual program plan file (See Chapter 9 on record-keeping).

TG-03 Selection of the Coordinator

TG-03.1 The individual program plan team should select one member to serve as the individual program plan coordinator.

TG-04 Responsibilities of the Coordinator

TG-04.1 The coordinator's responsibilities should be:

a) to convene and coordinate team meetings

b) to monitor implementation of the plan

c) to ensure that the work of the team is documented

d) to participate as a team member in the development, implementation and review of the individual program plan.

Team Responsibilities

Commentary

Team members share responsibility for the development, implementation and review of the plan. Team members share and discuss all relevant information available, and devise the overall plan as a group. Individual members of the team are assigned responsibility for ensuring the implementation of detailed programs in accordance with, and as elements of, the overall plan. Team activities in connection with development, implementation and review of the plan are discussed in greater detail in succeeding chapters.

TG-05 Responsibilities of the Team

TG-05.1 The individual program plan team is responsible for ensuring the development, implementation and review of the individual program plan.

TG-05.2 Responsibilities connected with development of the plan include:

a) providing the client/family/representative with orientation and information necessary for their participation as team members

b) obtaining specialized assessments or consultations as necessary

c) identifying the client's strengths, weaknesses and needs

d) determining appropriate goals

e) identifying means for accomplishing goals

f) assigning responsibility and target dates for plan implementation

g) preparing a written individual program plan.

TG-05.3 As assigned by the team, individual team members may have responsibilities connected with plan implementation. These responsibilities may include:

a) develop and carry out methods to accomplish goals

b) monitor client's progress towards goals

c) document methods used and client's progress.

TG-05.4 The team should review the plan as required, but at least annually.

5. ASSESSMENTS FOR INDIVIDUAL PROGRAM PLANNING

"Assessment" is, for individual program planning purposes, the process of identifying the individual's strengths, resources and capabilities as well as developmental handicaps and the ways in which the severity of these handicaps can be reduced. The intention of individual program planning is to maximize a person's growth and development by matching developmental needs to services and supports. Information from assessments assists the team in devising a program of action to enable the individual to move towards increasingly independent functioning.

Ideally, assessment should become an integral part of the individual program planning cycle. It should form part of an ongoing interaction between assessment services, the individual and his or her family, and service providers.

The consultation paper presented a comprehensive set of proposed standards and guidelines relating to assessment. These proposals were intended to encourage the integration of assessment into the individual program planning process. The assessment standards were directed to the individual program plan coordinator and team. They were focussed on establishing a locus of responsibility to ensure that adequate assessments be conducted and the results used in the individual program planning process.

The assessment guidelines were concerned with the details of assessment: when assessments should be done; the areas of functioning to be assessed; the choice of assessment instruments; where assessments should take place; who should conduct assessments.

During the consultation process, service providers expressed general agreement with the Ministry's intentions. Service providers did, however, raise several concerns:

- the individual program plan coordinator was given extensive duties in regard to assessment
- the proposed standards and guidelines appeared to suggest that a full and comprehensive assessment in every domain of functioning should be conducted prior to the development of the individual program plan.
- information from previous assessments may be either irrelevant or unavailable
- assessment resources are lacking, particularly in rural and remote areas.

While the overall thrust of the revised assessment guidelines remains unchanged, the guidelines and accompanying commentaries have been revised in response to these concerns. In brief,

- the coordinator's duties have been modified and shared with the team
- the emphasis on reviewing and summarizing previous assessment information has been reduced
- the need for assessment in each domain is understood to depend on whether the information is useful and necessary for the development of the plan.
- the Ministry continues to encourage service providers to obtain full and comprehensive assessments as necessary, but recognizes that interdisciplinary assessment resources are not always available.

In keeping with the overall direction of the revised policy paper, the assessment guidelines have been re-written to focus on the responsibilities of the team. They outline what the team can reasonably be expected to undertake with regard to assessments. Some of the guidelines which, in the consultation paper, were directed to assessment services have been deleted or re-written to reflect team responsibilities.

To assist individual program plan teams, the Ministry has published two other documents concerned with assessments for individual program planning. These include:

- **Directory of Assessment Services for Developmentally Handicapped People** (March, 1983; under revision)
- **Functional Assessment Instruments for Developmentally Handicapped People** (March, 1983)

Used in conjunction with the guidelines in this paper, these documents should assist service providers in improving the assessment component of individual program planning.

Role of Assessments in Individual Program Planning

Commentary

Standards developed in the United States by the Accreditation Council for Services for Mentally Retarded and Other Developmentally Disabled Persons (ACMRDD) describe what assessments should accomplish for individual program planning purposes. Assessments should:

- o determine whether, and to what degree, an individual has developmental handicaps
- o identify the individual's strengths and developmental needs
- o identify the conditions that appear to impede the individual's development
- o identify what services and supports are needed to move the individual towards increasingly independent functioning.

Assessment is important in each phase of the individual program planning cycle.

1. Development of the plan

Ideally, assessment would be done prior to the development of the individual program plan. Assessment would be carried out specifically to provide information for program planning. It would consider all aspects of the individual's development. It would identify strengths and needs and suggest specific methods to meet these needs.

In many cases, the available assessment information may not be adequate. The individual program planning team should make use of available information and depending on the situation, identify assessment as a need in a preliminary individual program plan.

2. Implementation

a) Assessment as a goal

When available assessment information is inadequate, obtaining a comprehensive assessment can be established as a goal in the individual program plan. The team would identify specific objectives for the assessment (i.e. formulate questions to be answered by the assessment) and assign responsibilities and completion dates.

b) Assessment as program monitoring

On-going assessment should be used to monitor the handicapped individual's progress towards goals established in the individual program plan. Program-monitoring assessments are not necessarily elaborate or comprehensive. They are nonetheless an important source of assessment information.

3. Review

If assessment is established as a goal in the individual program plan, the assessment information is then used in the review stage to prepare both a revised overall plan and implementation plans.

Information from program monitoring assessments is used during review of the plan. It helps to determine the appropriateness of goals and methods. It helps to identify new strengths and needs.

While assessment should be viewed as an ongoing process, three general types of assessment can be distinguished:

- Screening assessments: These assessments compare the individual's abilities in one or more domains with a set of norms based on the abilities of non-handicapped individuals. They do not examine an individual's abilities in detail nor do they determine the cause of the disability. They are used to establish whether a developmental handicap is present or to establish eligibility for a program or service.

- Functional assessments: These assessments focus on determining what skills or abilities an individual does or does not possess. Direct observation is used to develop a complete profile of an individual's competencies. Functioning is evaluated against a fixed standard of performance, rather than against the performance of others.

- Diagnostic assessments: These assessments determine whether, and to what degree, an individual has developmental deficits. They attempt to identify the conditions that impede the individual's development and the cause of the deficit. Ideally, they result in a prescription -- possible approaches to reducing or ameliorating the deficit. Diagnostic assessments will typically be carried out by professionally trained staff (e.g. medical doctors, audiologists, physiotherapists, etc.).

AG-01 Role of Assessments

AG-01.1 The team should ensure that functional, screening or diagnostic assessments are conducted as appropriate:

a) to assist in identifying the client's strengths and needs and in selecting appropriate goals

b) to assist in the development of training or habilitation approaches

c) to monitor an individual's progress in a particular training or habilitation program

d) to establish that a developmental handicap exists or to establish eligibility for a program or service, and in such a case should be kept to a minimum.

Identifying Assessment Needs

Commentary

The identification of assessment needs is a responsibility of the individual program plan team. The possible need for assessment should be considered whenever a placement is being planned or an individual program plan is being developed for a person with a developmental handicap. In addition, the need for assessment may arise as the result of change in the individual's situation or relationships that precipitates a change in the person's behaviour.

In determing the need for assessment, the team should consider whether information is required on all or only some aspects of the individual's development. Many possible approaches can be taken to exploring all facets of an individual's functioning. For example, an assessment could determine the individual's capacities and limitations in different environments -- in a workshop setting, in the kitchen, on the bus and so on. A widely used practice is to consider the need for assessment in the following domains:

- Physical development and health: The physical development and health needs of individuals with developmental handicaps include all aspects of health care, both physical and mental, required by all persons, as well as any special needs or aids associated with the specific developmental handicap. Regular preventive and remedial health care is essential in maintaining optimal health, which enhances development in all other areas.

- Sensorimotor development and skills: The individual's opportunities for development and participation in normal everyday activities are enhanced with increasing skill in and integration of the sensorimotor functions. These include control and coordination of the movement of eyes, hands, arms, legs and body, enabling the handicapped individual to have some functional interaction with his or her environment. Also included are balance, dexterity, mobility (ambulatory and non-ambulatory) and the use of information from the senses - sight, sound, touch, smell, and taste.

- Communication development and social skills: The sharing of ideas and feelings that form the bonds of interpersonal relations can be accomplished through verbal and/or non-verbal means. The facilitation of language development is founded on the experience of and opportunity for communication. Communication in turn affects the individual's ability to interact with and relate to his or her family and other people in his or her social network. To have something about which to communicate requires a life rich in experiences.

- Emotional and spiritual development: The development of a positive, realistic self-concept and emotional maturity influences/and is influenced by interpersonal relationships. Belonging, friendship, loving, and being loved form part of the essential nature of all persons. The handicapped individual needs opportunities to develop a sense of community with other people and his or her environment.

- Independent living skills: Growth in personal management and community living skills contributes to the dignity and independence of the handicapped person's life. Personal management skills include self and health care, food handling and preparation, household care and maintenance, and all other knowledge and skills or support that enable personal autonomy. Most people's lives are characterized by some interaction with their community. Being able to use transit, locate services, and be a consumer enhances the degree and quality of the individual's community life.

- Education/vocational skills: Learning and working are central to the lives of most people. The acquisition of knowledge and skills for thinking and learning is life-long and at certain times in the life cycle directed towards vocational activity. The opportunity to prepare for and engage in work and employment adds a new dimension to the life of the handicapped individual. Academic and vocational instruction should be commensurate with individual ability and potential, and should reflect the realistic aspirations of handicapped persons and their families or representatives.

- Recreation/leisure: Recreation and leisure activities make free time enjoyable and satisfying. and provide natural opportunities for self-expression, social interaction and emotional growth. These activities may be planned for the handicapped person or eventually self-initiated, and will help to ensure personal and community integration.

These domains are discussed in more detail in Appendix C, page 80. Other domains of importance to the individual may, of course, be considered.

Developmentally handicapped people differ in their assessment histories. Some will not have been thoroughly assessed prior to initial individual program plan development. Others may have recently received a comprehensive multi-disciplinary assessment. Still others may have a history of repeated assessments.

Unnecessary repetitions and/or duplications of assessment should be avoided. They can be both intrusive and de-humanizing. Further, they make wasteful demands on scarce assessment resources.

Repetitive assessments can best be avoided by a thoughtful review of information already available. This should be combined with a review of the information required for making placement decisions or developing intervention strategies. Routine screening intake, admission and assessment procedures should be kept to a minimum. More elaborate, specialized procedures should be added on the basis of individual needs.

The individual program plan team should be responsible for determining whether further assessments are needed. This should be done through consultation with the individual, his or her family and service providers. The team can assign responsibility for determining assessment needs to one team member.

The individual program plan team is also encouraged to seek advice from assessment professionals in making decisions on assessment needs. This will promote a continuing dialogue between service providers and assessment professionals. Such a dialogue will help develop the skills of service providers in identification of assessment needs. It will also help assessment professionals to understand the kind of information service providers hope to obtain from assessment.

AG-02 Identifying Assessment Needs

AG-02.1 The individual program plan team should determine through discussions with the client/family/representative and present/potential service providers and through consideration of information from previous assessments, whether assessments are required to provide information for:

a) a placement decision

b) planning training or habilitation goals and approaches.

AG-02.2 The individual program plan team should determine through discussions with the client/family/representative and present/potential service providers, whether additional information is required concerning the individual's:

a) physical development and health

b) sensorimotor development and skills

c) communication development and social skills

d) emotional and spiritual development

e) independent living skills

f) education/vocational skills

g) recreation and leisure skills

h) other domains as appropriate.

Making Assessment Referrals

Commentary

Assessments vary in their complexity and comprehensiveness. Some types of assessments can most appropriately be carried out by the staff of service-providing agencies. Others should be conducted by specially trained professionals, and may involve the use of sophisticated techniques and equipment. Regardless of the type of assessment, however, the usefulness of the assessment results will depend to a large degree on the information provided and the questions asked in the assessment referral.

The usefulness of assessment results can be increased if an assessment referral is accompanied by appropriate background information. The Ministry policy paper Clinical Assessment in Children's Services presented an outline of the type of information that should be collected and provided prior to assessment.(1) An outline of information to accompany an assessment referral adapted from that paper is attached as Appendix D, page 88. Some of this information may not be available prior to the assessment, while other items may not be relevant in a particular situation. Nevertheless, an assessment referral should attempt to explore these areas. Provision of this information will assist those who will conduct the assessment to understand what questions the assessment is supposed to answer.

The degree of formality required in presenting pertinent information will depend on where the referral is going. The team members may be affiliated with an agency that conducts assessments. In many cases, outside assessment services, unfamiliar with the individual, will be receiving the referral.

A referral to an external agency should be accompanied by a complete written summary (see Appendix D, page 88). In other cases, program staff will be conducting assessments as part of an ongoing monitoring of the individual's progress. Here, the referral process is essentially an internal one, and less formality is required.

Nonetheless, staff who are conducting such assessments should ensure that the same information as would be required for an external referral is noted in the individual's records. This will encourage staff to give thoughtful consideration to the purpose of the assessment and the kinds of information it should produce.

Assessment results will be more useful if the individual, his or her parents or guardian, potential service providers, and potential assessment sources are all involved in the referral process. This will include their participation in preparing the assessment referral. In many cases, the individual or his/her family or guardian can appropriately make the actual referral. As part of the individual program planning process, the team should take responsibility for ensuring that information on assessment resources is available. The **Directory of Assessment Services for Developmentally Handicapped People** can be useful in this. The team should also ensure that the person making the assessment referral is provided with the necessary background information to accompany a referral.

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1. Hood and Anglin, 1979 pp. 21-23.

AG-03 Assessment Referrals

AG-03.1 When an assessment is required, the team should obtain written permission to release information to and receive information from the assessment service. Written consent should be obtained from:

a) the client, where the client is sixteen years of age or older and has capacity

b) from the nearest relative (as defined in the Mental Health Act, R.S.O. 1980, ch. 262), where the client is sixteen years or older and does not have capacity

c) from the Committee appointed under the Mental Incompetency Act, R.S.O. 1980, ch. 264, where the client is 18 years of age or older and has been declared incompetent under the Act

d) from the client's parent(s) or the person with lawful custody where the client is not yet sixteen years of age.

AG-03.2 When a client is referred to an external service for assessment, the team should prepare a written assessment referral, containing:

a) the client's name

b) the referral source

c) a brief description of the client's recent assessment history

d) a clear description of the client's behaviour in the domains of concern to the team

e) a clear, concise statement of the questions to be answered by the assessment

f) a clear, concise statement of the way in which the assessment results will be used

g) signed consents to release of information.

Conducting Assessments

Commentary

The consultation paper (**Proposed Standards and Guidelines on Individual Program Planning**) contained guidelines on conducting assessments. Those guidelines were not directed to a particular audience. Rather, they described preferred practices that could be followed by any person carrying out assessments for individual program planning.

During the consultation process, the proposed guidelines received general support. It became apparent, however, that revised guidelines should be directed to the individual program plan team. First, many team members are likely to be responsible for conducting assessments and welcome assistance in strengthening their current practices. Second, specifying an audience for guidelines on conducting assessments should increase the impact on assessments for individual program planning.

The revised **Policy Guidelines**, therefore speak about team responsibilities with regard to conducting assessments. The guidelines presented in this document describe preferred approaches to conducting assessments. They assume that the information-gathering process will be carried out in different ways depending on the needs of the individual, the availability of assessment resources and the skills and preferences of different professionals. Functional assessments can be conducted by program staff, provided they are properly trained in the use of a particular test or instruments. Diagnostic asessments should be conducted by appropriately-trained specialists. Full and comprehensive assessments are most appropriately conducted by an interdisciplinary team.

The guidelines suggest that assessments should include observation and/or testing in familiar environments, and should focus on the individual's adaptive behaviour, or the manner in which the individual responds to environmental demands. This approach is recommended because:

- o behaviour observed in an unfamiliar setting may not represent the individual's behaviour in familiar settings
- o skills observed in isolation may not represent the level of skills manifest in other environments
- o observations of the individual's social and physical environments are necessary to determine the degree to which they facilitate or impede independent functioning
- o an assessment carried out in a familiar setting provides a valuable opportunity for professionals to use the assessment as a training experience for the individual's family and service providers.

The guidelines also propose criteria for the appropriateness, consistency and reliability of assessment instruments.

AG-04 Conducting Assessments

AG-04.1 The individual program plan team should request that functional assessments be conducted by the staff of service providing agencies involved with the client. These staff should have:

a) training and experience in services for the developmentally handicapped

b) training in objective observation of behaviour

c) training and practice in the administration of the particular assessment tools used by the agency.

AG-04.2 When the functional assessments conducted by service providers do not provide necessary information, the individual program plan team should request that specialized assessments be carried out by professionals trained and qualified in appropriate areas.

AG-04.3 The individual program plan team should request that interdisciplinary assessment teams conduct assessments:

a) where problems require several perspectives

b) where several possible solutions are involved

c) where resolution of conflicting opinions is needed.(2)

AG-04.4 Team members who conduct assessments should ensure that assessments include observation and/or testing of the individual in his or her familiar environments.

AG-04.5 Team members who conduct assessments should ensure that specialized assessments are conducted without separating individuals from their residences overnight, unless such separation is necessary for adequate assessment.

AG-04-6 Team members who conduct assessments should ensure that assessments include:

a) measurements of the client's adaptive behaviour

b) observations of behaviour in the individual's familiar environment

c) notation of what the individual is doing instead of expected or desired behaviours.

AG-04.7 Team members who conduct assessments should use a variety of information-gathering techniques, including:

a) interviews with those knowledgeable about the individual

b) direct observation of the individual's spontaneous behaviour in his or her familiar environment

c) direct observation of the individual in structured test situations.

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2. These conditions are adapted from Cosgriffe and Dailey, 1969.

AG-04.8 Team members who conduct assessments should use assessment instruments which:

a) have adequate inter-rater reliability

b) have some test/retest reliability

c) maintain internal consistency where feasible

d) have items and questions that correlate within domains.

AG-04.9 Team members who conduct assessments should use assessment instruments suitable in terms of:

a) age-appropriateness of materials and tasks

b) modifications to the assessment procedure and/or scoring system to allow for multiple handicaps

c) ethnic, cultural and linguistic aspects.

AG-04.10 Team members who conduct assessments should ensure that the assessment approach reflected in an instrument is appropriate to the purpose of the assessment:

a) Norm-referenced instruments should be used primarily for determining whether, and to what degree, an individual has developmental handicaps.

b) Criterion-referenced instruments should be used to develop learning targets for inclusion in an individual program plan.

Synthesis, Reporting and Follow-up of Assessments

Commentary

The next stage in the assessment process is the development of a synthesis of pertinent information. The synthesis involves the selection and integration of significant information from the assessment referral and the assessment observations.

- It results in a formulation that shows the significance of and the relationship between different factors in the individual's situation.
- It points the way to appropriate service and program planning.
- It identifies the kinds of assistance that might be useful to the individual.
- It makes an educated guess about the progress the individual can make towards independence.

The synthesis should be presented in the form of an assessment report. At present, results of many assessments are not useful for purposes of individual program planning because:

- o results are not shared adequately with families and service providers
- o highly technical language makes the reports difficult to understand, even for other professionals
- o reports are more concerned with diagnosis and labelling than with identifying creative ways of providing assistance
- o recommendations are often too general and lacking in specific detail.

The assessment report is essentially the answer to the questions asked by the assessment referral. It should:

- o present assessment findings in familiar and recognizable language
- o provide a non-technical summary of the evidence that contributed to the assessment findings
- o identify the individual's present level of functioning, specifying strengths and needs
- o make specific recommendations concerning service placement and individual training or habilitation approaches.

Follow-up is the final, essential ingredient of a useful assessment. Often, assessment results are not used because families and service providers do not understand the assessment results, do not accept assessment findings and recommendations, or do not have the skills or experience required to implement assessment recommendations.

The guidelines in this section are concerned with promoting adequate communication of assessment findings and adequate follow-up after an assessment has been conducted.

The revised guidelines are directed to the individual program plan team. The team should be responsible for asking assessment services to provide a report of assessment findings. The team should ask assessment services for necessary assistance in implementing assessment recommendations.

AG-05 Synthesis, Reporting and Follow-up

AG-05.1 The team should ask the assessment service to provide a written summary of assessment findings written in clear, understandable language. The written summary should include:

a) source of the assessment

b) informants in the assessment process

c) dates and locations of observations and testing

d) tests procedures and instruments used

e) major findings concerning the individual's development, his or her social network and his or her physical environment

f) identification of strengths and needs.

AG-05.2 The team should request the assessment service to provide, as required, the necessary assistance with interpretation of assessment findings to:

a) the individual and the individual's family

b) those directly involved in the provision of service to the individual.

AG-05.3 The team should request the assessment service to assist the individual, his or her family and service providers to develop the skills required to implement assessment recommendations. This assistance could take the form of:

a) demonstrations of training and habilitation techniques

b) provision of detailed written instructions on how the recommendations should be implemented.

6. DEVELOPMENT AND CONTENT OF THE PLAN

The individual program plan is developed by the individual program plan team. Team members, including the developmentally handicapped individual, meet to share their knowledge and experience. The team works together to develop the plan, basing their decisions on:

- the results of current and relevant assessments
- the interests, wishes, likes and dislikes of the handicapped individual and the family or representative
- any other information that assists in understanding the individual's situation.

In the process of goal planning, the team identifies:

- the individual's present level of functioning, specifying strengths and needs
- appropriate goals for the individual
- means of achieving these goals.

The outcome of the planning process is an overall individualized plan for meeting the client's needs. This overall plan will be made up of a number of service and program components. The purpose of developing an overall plan is to show how these components will work together to meet the client's needs.

Development of the Individual Program Plan

Commentary

The individual program plan sets out service providers' responsibilities to the developmentally handicapped individual. The individual program plan should, therefore, be developed soon after the client becomes involved in the service delivery system.

The **Proposed Standards and Guidelines** recommended that the individual program plan be developed within 30 working days of the client's admission to a service. The intent of establishing a time limit was to ensure that the client is not in a service indefinitely without program goals. Service providers raised two concerns about this recommendation:

- the point signifying "admission to a service" needed to be defined
- for service providers working in residential settings, particularly with adult clients, 30 working days was too short a time to develop a full plan. Respondents from children's services did not voice the same degree of concern.

In most situations, the point at which the client is admitted to a service will be clear. At times, however, there may be questions regarding what constitutes "service". This is particularly apt to be the case at either end of the service delivery continuum. Should assessment be considered as the point of initiation of service? Should follow-up and after-care be considered services? When do services terminate?

The variety of service models complicates the question of what constitutes "service". Some agencies provide intake or screening assessments, for example, to determine the suitability of match between the client and their services. Others perform thorough multidisciplinary assessments as the first stage in the ongoing provision of service.

Given the diversity of approaches and practices, the revised **Policy Guidelines** avoid defining the provision of services in such terms as "assessment" or "after-care". For the purpose of individual program planning, what is important is that a decision to accept responsibility for a client has been made. Once a service provider makes such a decision, an individual program plan should be developed.

As a preferred practice, the guidelines recommend that the team should at least initiate the development of a written plan within 30 working days of the client's admission to a service. In some instances, information important for decision-making may not be available, and hence the plan cannot be completed within this time-frame. For example, a lengthy vocational assessment might be required before a complete plan can be made. In such situations, the guidelines suggest that the team establish a target date for completion of the plan.

The team meeting is a key point in the development of the individual program plan. At the team meeting, the members share information and discuss possible courses of action. The team makes important decisions that will have a significant effect on the client's life. The outcome of the team meeting is a clear statement of team members' responsibilities to the handicapped individual.

The team as a whole should meet at least once to develop the plan. Informal meetings and/or telephone conversations can be used to supplement the formal meeting. Additional meetings of the whole team can be called as required.

The handicapped person and/or his or her family or guardian or representative, as appropriate, should participate in all decision-making meetings. The client should receive an explanation before the meeting of what will be discussed, how the meeting will be conducted and how he or she is to participate. The client also needs to know how his or her personal concerns can be presented and who will assist him or her in interpreting what is happening.

In areas where there are significant concentrations of francophones, team meetings should be conducted in French if the client is French-speaking or in English if the client is English-speaking. For clients whose language is other than French or English, service providers are encouraged to arrange for a translator to be present at team meetings.

Assistance in preparation for and during the meetings is intended to maximize the client's participation. Ensuring and assisting his or her participation respects that person's human worth. His or her presence will also benefit the decision making of the group united in the attempt to strive for maximum development of potential.

DG-01 Development of the Individual Program Plan

DG-01.1 The team should at least initiate the development of a written individual program plan within 30 working days of the client's admission. If the plan has not been completed within 30 working days, the team should establish a date for completion.

DG-01.2 Team meetings should be scheduled in advance and at a time that allows for the attendance of the client/family/representative. If the client/family requires assistance or interpretation during the meeting, arrangements for such assistance should be made in advance. If a team member cannot attend a meeting, his or her input should be sought prior to the meeting and he or she should be informed of the outcome of the meeting.

DG-01.3 The team should meet at least once to develop the individual program plan. Additional meetings should be convened when the need is indicated by changes or problems and should be attended by relevant members.

Goal Planning

Commentary

Proper planning is essential to identifying and meeting the handicapped individual's needs. The goal of the planning process is to produce statements of intent that prescribe positive change based on team decisions as to what will have impact on the handicapped person's life, and foster development, normalization and integration.

During the consultation process, service providers generally supported the idea of goal planning. Three major concerns were voiced.

- The consultation paper outlined domains to be considered in identifying needs and formulating goals. The listing of domains was incomplete and/or inappropriate for some clients.

- The formulation of a goal related to each domain may not be necessary for all clients.

- The consultation paper recommended that three goals be given priority for implementation. Service providers felt the number should be flexible.

This commentary and the following guidelines have been modified in response to these concerns. Although the major portion of this section has been reproduced from the consultation paper, changes in wording and emphasis have been made. Most importantly, the suggestion of three top priority goals has been removed. Instead, the team is invited to use its judgement in selecting an appropriate number of goals, basing its decision on the individual's needs and the resources available.

Goal planning is based on the analysis of all observations and assessments to plan future action. The input of all team members is necessary to generate overall goals, which are usually long-term and intended to ensure the facilitation of positive change and growth in the handicapped person's life.

The goal planning process will vary somewhat in relation to the situation and the style of team members. Decisions involve judgements, and reflect personal and group values. The ease with which a team makes decisions will be related to the degree of shared values and philosophies, group leadership and the use of some model for decision making. The underlying tone, nonetheless, should always be positive and client-centred. Individual programs should emphasize skills and supports needed for success, rather than focussing on deficits or weaknesses.

Identifying strengths and needs as part of the goal-planning process should lead to a positive and productive focus in working with people with developmental handicaps.

Strengths include aspects of the handicapped person's life - skills, aptitudes, interests or relationships - that are positive characteristics that may enhance progress, facilitate learning, or serve as prerequisites for more complex skills. Beginning the goal-planning process with a review of strengths helps to emphasize positive apects of an individual's behaviour, abilities and life instead of disabilities and problems.

Needs are areas where the handicapped person requires assistance in progressing towards or maintaining a life that is as normalized and integrated as possible. Needs refer to a lack of skill, support or behaviour that is useful, required or desired, and reflect what the individual has yet to learn, to do or to acquire.

Needs statements, though often varying in their specificity, are generally positive statements describing what the handicapped individual should be doing or should have. In essence, they describe program outcomes without necessarily referring to the means of arriving at these outcomes. The statements should use positive terms in order to emphasize growth and positive change instead of intervention aimed only at decreasing, or eliminating behaviours.

All aspects of an individual's functioning should be explored in identifying strengths and needs. One way to approach this exploration is to consider the individual's abilities in different domains of functioning. In this process, individual program plan teams are invited to use the domains listed in Chapter 5 and Appendix C, page 80.

To require that domains of human activity be described is not to suggest that a human being's existence can be fragmented. Training or support in one area inevitably affects other aspects of an individual's life. Focussing on only one domain is to see only an isolated, incomplete part of an individual's life, and any assistance or support offered in this way may prove useless or counterproductive in relation to the individual's overall goals.

On the other hand, suggesting that all domains be considered during the goal planning process does not imply that the individual will have a need in each domain. Some individuals will have a small number of specific needs that can be met by specific interventions. Only some clients will require an individual program plan that establishes goals for all domains. Service providers are nonetheless encouraged to explore possible strengths and needs in all domains so that the client's significant needs will be identified.

Having identified the individual's needs, the individual program plan team can formulate related goals, which are essentially general statements of program intent and outcome, in language that is understandable and measurable. The goals stated in the plan are overall goals in that they are general, broad or complex. Overall goals are often long-term, in that considerable time may pass before they are accomplished; however, overall goals may sometimes be achieved in a relatively short space of time.

The team will usually have to establish priorities amongst overall goals. The ability to respond to all of an individual's identified needs may be limited by the availability of resources, equipment, people, and even time. Resources need to be allocated first to the most significant goals for the individual.

Priorities are established by the team with full client participation and after consideration of the client's own priorities and those of his family, (especially if the client is a child), his community and agencies that may be serving him. Top priority should be given to the goals that will have the most impact on the quality of the handicapped individual's life. Goals not given priority at this time should be noted for review at the next team meeting.

The team should also set starting dates for program implementation, completion dates for high priority goals and dates for review of the plan. Implementation plans for top priority goals should begin as soon as possible after the team meeting, and specified starting dates help to ensure that an important program is not delayed.

Completion dates are most often only estimates of when a goal may be accomplished. They have value, however, in that they reflect the positive view that the goal can indeed be accomplished, and they serve as a "deadline" towards which to work. Dates for review of the plan will be at least annual, or more frequent, at the discretion of the team. The implementation process itself will involve more frequent reviews of client progress towards short-term objectives.

DG-02 Goal Planning

DG-02.1 The team should identify the client's strengths, and needs based on consideration of the individual's present level of functioning in:

a) physical development and health

b) sensorimotor development and skills

c) communication development and social skills

d) emotional and spiritual development

e) independent living skills

f) education/vocational skills

g) recreation and leisure skills

h) environmental circumstances

i) other domains as appropriate.

DG-02.2 The team should:

a) formulate objectively-stated goals related to the individual's needs

b) determine which of the goals are high priority

c) identify means of accomplishing high priority goals

d) assign responsibilities and dates for accomplishment of high priority goals.

e) note goals not given priority, for review at a later date.

Content of the Individual Program Plan

Commentary

The individual program plan is a written plan for action, outlining steps to meet personalized goals for the developmentally handicapped person. The written individual program plan should be designed to document, in summary form, all important decisions reached by the team and the basis for these decisions.

Service providers generally agreed with the content of the individual program plan as outlined in the **Proposed Standards and Guidelines**. The revised guidelines on content have been modified slightly, the most significant change being removal of the requirement for a set number of high priority goals.

The guidelines suggest that the written individual program plan should include:

- o the individual's strengths and needs
- o overall goals, expressed in measurable terms
- o priorities amongst the overall goals
- o responsibility for accomplishing high priority goals
- o assigned dates for implementation, review and projected completion of programs related to at least the high priority goals
- o signatures of all team members.

The language used in the written plan should be concrete. It must be understandable to non-professional team members, including the developmentally handicapped individual and/or his or her family and/or representative. The written plan must be meaningful for planning action; that is, it must clearly and simply identify "who", "what", "when", "where" and "why".

The particular format used for the individual program plan can vary, with key content items recorded in a number of different ways. Service providers are encouraged to consider several formats and select one that is suitable for their own needs. To assist with this, two sample formats are provided in Appendix E, page 90.

DG-03 Content of the Individual Program Plan

DG-03.1 The written individual program plan should:

a) identify strengths that may positively influence further development of the individual

b) identify the individual's needs

c) state measurable overall goals

d) identify high priority goals and means for accomplishing these

e) state the name of the team member who will be responsible for ensuring the implementation of means to accomplish each goal during the time until the next team meeting

f) state assigned dates for implementation, review and projected completion of means to accomplish at least the high priority goals

g) contain the signatures of all team members.

DG-03.2 The individual program plan should be written in language understandable to all concerned and expressed in concrete terms meaningful for planning action.

7. IMPLEMENTATION OF THE INDIVIDUAL PROGRAM PLAN

Implementation of the individual program plan refers to provision of the supports, services and/or programs needed to accomplish overall goals. Members of the team are assigned responsibility for the design, implementation and evaluation of methods to accomplish goals, in accordance with the overall plan. Implementation plans are used to document both the chosen methods and the client's accomplishments in written form.

Implementation Plans

Commentary

The **Proposed Standards and Guidelines** discussed the need to document the implementation process in written form. During the consultation process, service providers asked the Ministry to clarify the relationship amongst written individual program plans, written implementation plans and written plans such as individual training plans, individual habilitation plans, individual educational plans, or infant development plans.

In the revised **Policy Guidelines**, a written implementation plan is understood to be a component of an overall individual program plan. The implementation plan can be referred to as a training plan (ITP), habilitation plan (IHP), educational plan (IEP) or infant development plan (IDP). The service areas, disciplines or professionals involved may employ methods for implementation and evaluation, design formats, and adopt names that are appropriate to their own involvement. (See Appendix F, page 96, for sample formats.) A written implementation plan or plans would be prepared by the team member assigned responsibility for a particular goal. The guidelines suggest that the written implementation plan should specify program objectives, methodology and monitoring or evaluation approaches.

The written implementation plan begins by setting specific objectives related to the broad, overall goal(s) stated in the individual program plan. Whereas goals are general statements of intent, the objectives of an implementation plan are more precise statements of expected accomplishments or outcomes.

The implementation plan may define a number of specific objectives, leading to accomplishment of an overall goal. The specific objectives should be stated in terms that are observable and measureable, and indicate what the client will do, under what conditions and how well. For example, an overall goal may be "independent use of public transit". Specific objectives could be formulated as "Alice will use the city bus to travel to and from work without supervision" and "Alice will use the city bus to travel to and from church without supervision".

Well-stated objectives benefit the client in that they provide a basis for evaluating his or her progress. The benefits to the teacher/helper are that they provide a basis for evaluating the service provider's effectiveness, and aid in the selection of materials or methods. Measurable objectives also communicate clearly to all involved persons how the client may progress.

All implementation plans are alike in that they state the methods of intervention for achieving the goals in the individual program plan. Methods chosen are likely to vary both in nature and intensity. Team members can choose from a range of possible approaches -- a mediator/consultant model, environmental modifications or a behaviour management program, for example. The methods selected should be appropriate to the goal and match the style and circumstances of the developmentally handicapped person.

Which implementation method is appropriate will depend on the client's needs, the nature of the goal and the availability of resources. For one client, methods involving counselling, support and advocacy may be appropriate. Another client may need treatments of a medical or rehabilitative nature. For still another, an educational or training approach may be required to teach new skills or to modify specific behaviours.

An implementation plan should sufficiently describe the methodology so that other persons may concurrently or consecutively implement the program in a consistent manner. Some programs are successfully implemented with the assistance of a group of staff and/or volunteers. The need for a detailed description of the teaching/helping process is clear in this case. When a program is implemented only by a key staff person, there may seem to be less need for a documented implementation plan. Nonetheless, since staff people may leave, a written, detailed implementation plan may add significantly to the continuity in a handicapped person's life, and minimize setbacks due to staff changes.

The method of evaluation should also be specified in the plan with specifications of the type of data to be collected and how it is to be recorded. The structure and precision involved in evaluation will be related to the nature of the intervention method. An intervention aimed at correcting a medical problem would be evaluated quite differently from one aimed at establishing self-care routines.

Implementation plans are current plans of action, and must be revised to reflect the degree of progress towards objectives. They are likely to undergo many minor revisions between meetings of the team. The number of revisions necessary will be related to the rate of the client's progress and the complexity of the overall goal.

IG-01 Implementation Plans

IG-01.1 Team members assigned responsibility for individual program plan goals should ensure that written implementation plans are developed to accomplish those goals within the assigned time frame.

IG-01.2 All written implementation plans should specify:

a) the client's name

b) the individual program plan coordinator

c) those involved in implementation, including key program staff and family members

d) objectives expressed in observable and measurable terms, with each objective referring to a single, separate outcome designed to lead to the achievement of the overall goal

e) all tasks or activities in the implementation methodology and the location and frequency of contact chosen to achieve each objective

f) a means of evaluating the success of the program through measurement of the client's progress

g) dates for commencement, review and projected completion of the implementation programs.

IG-01.3 Objectives should be:

a) time limited

b) stated in observable terms that provide measureable indicators of progress

c) derived from a sequential progression towards the overall goal.

d) appropriate to the client's age and ability.

IG-01.4 Tasks and activities in the implementation methodology should:

a) take place in settings appropriate to the chronological ages, developmental needs and cultural norms of the individuals being served

b) use age-appropriate materials and methods

c) utilize, as extensively as possible, generic resources

d) provide ongoing opportunities and support for experiences and relationships with non-handicapped people.

IG-01.5 The client's progress towards specific objectives should be measured and recorded using an appropriate schedule (ongoing, daily, weekly), but at least monthly.

Monitoring

Commentary

The guidelines encourage regular monitoring of the implementation phase of the individual program planning process. Monitoring helps to ensure that the individual program plan is implemented. If a team member encounters difficulties in implementing his or her assignment, other team members' assistance and advice can be sought.

Monitoring is a cooperative effort on the part of the individual program plan coordinator and the team members. Team members should keep the individual program plan coordinator informed of the client's progress. This could involve brief telephone calls or providing a copy of progress reports or other methods suitable to the circumstances. If serious difficulties arise in implementation (a particular service or program is not available, for example), the team member should contact the coordinator. Other team members or the team as a whole could then be asked to assist in resolving the problem.

The coordinator should try to contact team members regularly to determine that the individual program plan is being implemented. The frequency of contact needed will depend on individual circumstances. If the coordinator becomes aware of difficulties in implementation, he or she should seek advice and assistance from other team members and/or other resources. If necessary, existing intra- and inter-agency channels could be used to resolve difficulties.

IG-02 Monitoring

IG-02.1 Team members responsible for implementation should:

a) inform the coordinator that the tasks and activities described in the implementation methodology are being carried out according to the start and completion dates established in the implementation plan.

b) inform the individual program plan coordinator of the client's progress towards overall goals

c) inform the coordinator of serious difficulties in implementation.

IG-02.2 The individual program plan coordinator should:

a) regularly contact team members responsible for implementation to determine that plans are being implemented.

b) seek the advice and assistance of other team members if difficulties in implementation occur.

8. REVIEW OF THE INDIVIDUAL PROGRAM PLAN

Review is a process in which information obtained during and after plan implementation is interpreted in order to make judgements as to the existence, degree and nature of change. Plan review is concerned primarily with the extent to which overall goals have been accomplished. This is reflected in improvements in the handicapped person's quality of life, relationships and personal competence.

During the consultation process on the **Proposed Standards and Guidelines**, service providers asked for guidance on the frequency of reviews. The revised **Policy Guidelines** suggest a minimum of an annual review. With many clients, more frequent reviews will be necessary. With young children, for example, a weekly or monthly review may be required. The team should establish a review schedule appropriate to the needs and abilities of the developmentally handicapped individual. The team should also be prepared to carry out unscheduled reviews when warranted by individual circumstances.

In reviewing the plan, objective information about the handicapped individual is used to compare events and outcomes with the goals stated in the individual program plan. These comparisons permit an assessment of the nature and degree of change as related to the goals formulated by the team. This assessment process, in turn, contributes to decisions related to program or placement change.

The information reviewed by the team is drawn from both ongoing stages of the program and overall program outcome. Since human judgements are frequently inaccurate, the need for action or change must be substantiated by factual, verifiable information. Team members responsible for implementation should present information on the client's progress, sources of error, appropriateness of materials and methods, the environment and the teacher/helper.

The team should also examine the final outcome of programs. When goals have not been accomplished, the team may review the appropriateness of the goals themselves or the suitability of methodology, staff, materials or other resources.

The review should produce a revised individual program plan. The extent of revision required will depend on particular circumstances. In some cases, the team may only need to establish new target dates for accomplishing high priority goals. In other situations, goals may remain unchanged while different methods and responsibilities for implementation are needed. At times, a new set of goals and attendant implementation methods, responsibilities and target dates will be required.

A review should also take place when a new service provider joins the individual program plan team (see Chapter 4, p. 23, TG-02.5). This review will familiarize the new team member with an existing plan and may lead to the development of a revised plan, reflecting the contribution of the new team member.

In review of the plan, the client and/or his or her family/representative should participate as fully as possible. The same considerations with regard to client participation in development of the plan (Chapter 6, p. 43, DG-01.2) also apply to reviews. The team could appoint one member to assist the client and/or parent/representative to participate in reviews and to explain the implications of review decisions.

RG-01 Reviews

RG-01.1 The individual program plan should be reviewed at a minimum of once per year and

a) when information from implementation monitoring indicates a need for review

b) when the team has planned for more frequent reviews because of the nature of the client's goals.

RG-01.2 The individual program plan team should review all available information to:

a) determine the client's progress or lack of progress in response to the implementation plans

b) make necessary or useful modifications of goals, objectives or implementation plans

c) decide which programs, activities and supports are still needed or no longer needed

d) respond to the emergence of new strengths and needs

e) revise priorities amongst overall goals or new goals, if appropriate.

f) prepare a revised individual program plan reflecting review decisions.

9. INDIVIDUAL PROGRAM PLANNING RECORDS

Records are maintained by the individual program plan team members to ensure the effective planning, implementation, review, and supervision of all aspects of the individual program planning process. These individual program plan records are distinct from agency administrative records.

Benefits for the team of a well-focussed, well-organized system of record keeping include:

- o enhanced communication among the team through the use of consistent records that are easily located and identified by all those involved
- o the likelihood of team members more precisely organizing ideas and identifying issues that might otherwise have been overlooked
- o reduction of time wasted in record duplication and in recording and sharing irrelevant information.

During the consultation process on the **Proposed Standards and Guidelines**, service providers requested clarification concerning the content of records, access and confidentiality. With regard to content, two main issues were raised:

- o the extent of information to be kept in the individual program plan file
- o the relationship of the individual program plan file to other client-related files.

With regard to access and confidentiality, the major issues were:

- o where and by whom the individual program plan file should be kept
- o access of non-members to the individual program plan file.

The revised **Policy Guidelines** and accompanying commentaries address these concerns.

Contents and Maintenance of Records

Commentary

The individual program plan team is encouraged to establish an individual program plan file for each client. This file represents a chronological record of the individual program planning process for the client. It should contain a copy of the current individual program plan and copies of all current implementation plans. Current review and evaluation data should also be kept in the file.

The guidelines suggest that copies of previous individual program plans be retained in the file for a five year period. Previous implementation plans and review and evaluation data for the proceding five years should also be retained. When the client is an infant or a child, however, retaining this information in the individual program plan file may not be practical. Depending on the quantity of information involved, service providers may prefer to store this information separately rather than retain it in the individual program plan file. That is, such material should be available for reference but not necessarily kept in the individual program plan file.

This file should include background information on the client and the client's family and living situation, as well as anecdotal reports, and case notes that are relevant to the individual program plan process. Relevant background information may, for example, enhance or suggest limits on the developmentally handicapped person's opportunity and potential for growth. Relevant anecdotal reports may describe an unanticipated event or behaviour that relates to an individual program plan objective. A case note may give an account of the client or other involved person expressing opinions or ideas related to the individual program plan process.

Minutes of team meetings and correspondence about the individual program planning process should be kept on file. Legal documents, such as client consents to release of information should also be retained in the file.

The guidelines suggest that the team appoint one member to assume responsibility for maintaining the individual program plan file. This may be the individual program plan coordinator or it may be another team member. The choice will probably depend on which team member has access to clerical support, copying services and so on.

The use of a standardized format for the individual program plan enables the maintenance of records that are functional, precise and concise. Routine paperwork may be assigned to support staff, such as a secretary, to reduce the workload of team members. Sample formats are provided in Appendix E, p. 90, for agencies not yet using an individual program plan format or considering modifying their own format.

Following each individual program plan review, the team member responsible for the file should record a summary of the progress of each individual program as well as new programs and objectives set. The summary format provides an ongoing overview of the outcome and effectiveness of the individual program planning process. A standardized format should be used to simplify record-keeping. A sample summary format is provided in Appendix G, p. 99).

The individual program plan file should be separate from other client-related files (e.g. medical files, agency administrative files).

Each team member should have a copy of the individual program plan. This includes the client and/or parent(s), if they are team members, and/or the client's representative.

Individual team members are also encouraged to record information related to his or her aspect of involvement. Each team member should have a copy of any implementation plan for which he or she is directly responsible. In addition, any team member responsible for a particular goal should keep progress monitoring and evaluation data on file.

The individual program plan and implementation plans are working documents. They must be easily accessible for reference. If an agency's client records are readily available to direct service providers, a team member's copies of the individual program plan and implementation plans could be filed with existing records. If files are not normally located close to program areas (as might be the case in a large service-providing agency), individual program plans and implementation plans should be kept at the program location.

FG-01 Content of Records

FG-01.1 Each client should have an individual program plan file containing the following:

a) background information on the client including health/medical information, information regarding relationships with family and/or living group, and developmental history

b) anecdotal reports, case notes and correspondence relevant to the individual program planning process

c) current individual program plan and previous plans for up to the preceding five years

d) current implementation plans

e) current review and evaluation data

f) minutes of team meetings

g) legal documents relevant to the individual program planning process, including release of information agreements and contracts between the client and service providers.

FG-02 Maintenance of Records

FG-02.1 The team should identify one member who assumes responsibility for maintaining the client's individual program plan file.

FG-02.2 Each team member, including the client and/or parent(s) and/or representative, should have a copy of the current individual program plan as well as information related to his or her particular aspect of involvement, including past and current implementation plans. This may be a separate file or it may be integrated with an existing client file.

Access and Disclosure

Commentary

The Ministry is developing policy in the area of access by clients to their own records and disclosure of client information to third parties. The guidelines on individual program planning which concern access to files and disclosure of information reflect the direction of Ministry policy in this area. It must be emphasized that these access and disclosure guidelines are in all instances subject to the provisions of existing legislation. For example, child abuse and adoption information continues to be subject to the special provisions contained in the Child Welfare Act, 1978, R.S.O. 1980, chapter 66.

The safeguarding of the client's right to personal privacy is an important consideration in determining record-keeping procedures and practices.

At the same time, participation by team members in decision making requires access to adequate client information. As a general principle, it is considered that individual program plan files will contain only documents strictly relevant to the plan. All team members should, therefore, have access to the individual program plan file. This will include, as appropriate, the client and his or her representative. If they are team members, the client's parent(s) or the person with legal custody should also have access to the file.

In many service-providing agencies, the delivery of a particular program may involve agency staff who are not team members. In such a situation, these staff members should also have access to information necessary to their work from the individual program plan records.

Specific written consent is required for the disclosure of information to persons other than individual program plan team members or to agency staff who are involved in delivering programs or services to the client. This consent should be obtained:

- from the client, where the client is sixteen years of age or older and has capacity
- from the nearest relative, where the client is sixteen years of age or older and does not have capacity
- from the client's parent(s) or the person with lawful custody where the client is not yet sixteen years of age.

The terms "capacity" and "consent" are drawn from definitions used in Bill 77, An Act respecting the Protection and Well-being of Children and their Families. To assist the reader, definitions of these terms are provided in Appendix B of this document, page 74.

The term "nearest relative" refers to the definition used in the Mental Health Act, R.S.O. 1980, ch. 262. This definition is reproduced in Appendix B, page 77.

Attention must also be paid to the physical security of files, since a developmentally handicapped person may have lifelong service needs, and be involved in the individual program planning process over many years.

Reasonable precautions should be taken to safeguard files against access by unauthorized persons and against loss or destruction. These precautions should not, however, restrict the access of authorized persons to the files. The individual program plan must be accessible for ready reference by those working to implement the plan.

FG-03 Access and Disclosure

FG-03.1 All team members including the client, his or her representative, and parent(s) if they are team members, should have access to the individual program plan file.

FG-03.2 All information contained in the individual program plan file should be considered confidential and secured against access by unauthorized persons, loss or destruction. Specific written consent for the disclosure of information to persons other than individual program plan team members should be obtained:

a) from the client, where the client is sixteen years of age or older and has capacity

b) from the nearest relative (as defined in the Mental Health Act, R.S.O. 1980, ch. 262.), where the client is sixteen years of age or older does not have capacity

c) from the Committee appointed under the Mental Incompetency Act, R.S.O. 1980, ch. 264, where the client is 18 years of age or older and has been declared incompetent under the Act

d) from the client's parent(s) or the person with lawful custody where the client is not yet sixteen years of age

e) except in the case of child abuse, where personal records may be released in accordance with the Child Welfare Act, R.S.O., 1980, ch. 66.

10. AGENCY SUPPORTS FOR INDIVIDUAL PROGRAM PLANNING

Supports for individual program planning include the values and philosophies, activities and practices, and available resources of all participants and agencies involved in the individual program planning process, which together enable the delivery of a quality service to all clients.

During the consultation process, agencies expressed general support for the individual program planning initiative. They were concerned, however, about the availability of resources to support individual program planning. The Ministry recognizes this concern. As a first measure, the Ministry is providing financial and administrative support for pilot training projects.

Agencies also have a responsibility to use existing resources effectively. Individual program planning contributes to effective use of resources by:

- ensuring that programs and services are related to client needs
- reducing overlaps in service provision
- providing a systematic framework for service planning.

Philosophy and Practice

Commentary

An agency that has a stated philosophy and set of goals in keeping with the individual program planning foundation principles of normalization and the developmental model sets the stage for successful individual program planning.

It is important that philosophies and goals be consistent throughout the agency, as reflected by the values and actions of all levels of agency hierarchy, from the front-line worker to the policy-making body.

The individual program planning process works best when there is effective interagency collaboration, with team members cooperating and working together throughout the process. Such collaboration is greatly facilitated when team members have a shared philosophy. By bringing into congruence their agencies' philosophies, team members are able to work more effectively towards shared goals and objectives.

The individual program planning process is further facilitated when the practices and activities of an agency are consistent with the needs of the individuals served, as reflected in the agency's philosophy and goals.

SG-01 Philosophy and Practice

SG-01.1 Agencies should have written statements of philosophy and goals that reflect the principle of normalization and the developmental model.

SG-01.2 Agencies and individual program plan team members should collaborate to develop and share congruent philosophy, practices and activities that are in keeping with the principle of normalization and the developmental model.

Administrative Supports

Commentary

Agencies serving people with developmental handicaps should develop administrative supports for the individual program process. For example, if an agency has many clients involved in individual program planning, a schedule showing individual program plan-related events should be developed. Such a schedule will assist the agency to plan for meeting rooms, staff assignments and so on. A reminder system to provide advance notice of upcoming individual program plan-related events will assist both the agency and involved staff members to be well-prepared for team meetings and review conferences. A sample schedule is shown in Appendix H, p. 100.

Agencies should also provide secretarial and/or clerical support for staff members who are individual program plan coordinators or team members. The use of standard formats for record-keeping (as discussed in Chapter 9) will help to keep secretarial requirements to a minimum.

SG-02 Administrative Supports

SG-02.1 Agencies serving people with developmental handicaps should maintain schedules showing individual program plan-related events for all developmentally handicapped clients. These schedules should contain the following information:

a) client names

b) names of individual program plan coordinators

c) names of responsible team members/facilitators

d) assessment dates

e) individual program plan conference dates

f) internal agency individual program plan review dates.

SG-02.2 A reminder system such as a "bring forward" file system should be developed to provide advance reminders of upcoming individual program plan-related events.

SG-02.3 Agencies should provide secretarial and/or clerical support to staff members who are individual program plan coordinators or team members.

Evaluation

Commentary

The systematic evaluation of agencies involved in the individual program planning process is another important means of ensuring the continuing success of the process. Regular program evaluation should review the success of the agency's services in terms of the degree to which individual program plan objectives are achieved, and also in terms of agency achievements against stated agency individual program planning goals. Coupled with this ongoing program evaluation should be a mechanism for the consequent review and modification of agency operations.

Evaluation is a complex process. A description of an adequate evaluation is beyond the scope of these guidelines. The Ministry has, however, addressed evaluation issues in other documents. For example, Chapter 4 of **Community Residential Services for Developmentally Handicapped People (April 1983)** discusses evaluation. Agencies are encouraged to consult that document and other resources to develop appropriate evaluation methods.

SG-03 Evaluation

SG-03.1 Agencies should evaluate their individual program planning and service delivery system at least annually.

Staff Training and Development

Commentary

An agency's policies and procedures frequently address issues involving staff development. For staff to participate effectively in individual program planning, they must be adequately trained and qualified. Board members, volunteers, parents and resource professionals all need to be well-versed in the philosophy and practice of individual program planning. The individual program planning process is facilitated when an agency's approach to training reflects the same philosophy, supporting individual growth and development, that it applies to the clients receiving service.

One important component of a good staff training program is an orientation for all new staff, to familiarize them with the process of individual program planning in the agency. Other training opportunities could include such means as staff meetings, seminars, conferences, and college and university courses; visits to other agencies; participation in professional organizations; participation in research studies; and use of a library for professional updating.

During the consultation process, agencies requested assistance with training their staff in individual program planning. In response, the Ministry has initiated several pilot training projects (described in Chapter 1). Further training efforts will evolve from cooperative action on the part of the Ministry, agencies and community resources such as universities and community colleges.

SG-04 Staff Training and Development

SG-04.1 Agencies should participate in community planning of training programs in individual program planning for direct service staff, administrators, board members, volunteers and other potential participants.

SG-04.2 Staff training programs in individual program planning should:

a) cover agency philosophy, goals, structure, policies, programs, practices, procedures and the individual program planning process

b) include an orientation for all new staff.

Staff Appraisals

Commentary

Regularly scheduled staff appraisals play an important role in the process of staff training and development, and provide the motivation and support for each staff person to identify and work on his or her job-related strengths and needs. Appraisal of staff performance in developing and implementing individual program plans is essential to determining each staff person's training and development needs in this area, and to improving the overall individual program planning process in the agency. It is desirable that the appraisal be recorded in writing.

SG-05 Staff Appraisals

SG-05.1 Agencies should carry out an annual appraisal of each employee's performance in developing and implementing individual program plans, if participation in individual program planning is one of the employee's duties.

SG-05.2 Agencies should record the appraisal in writing, and give the employee the opportunity to review and respond to the appraisal.

Volunteers

Commentary

Volunteers provide a valuable resource, increasing opportunities for the growth and development of the people being served according to individual program plans. As indicated previously, a volunteer who represents the client may become part of an individual program plan team. Volunteers can provide support to individual program planning through provision of both direct and indirect services. For example, volunteers may transport clients, set up program sessions, or act as aides to direct care workers.

The use of volunteers raises issues of coordination, training, supervision, confidentiality and cost that require careful consideration by the responsible agency. For maximum benefit from this resource, an agency planning to introduce or expand a volunteer program should consult other agencies with extensive experience with volunteers before establishing explicit policies regarding volunteer recruitment and assignment. Decisions regarding volunteer assignments should consider the needs and preferences of the developmentally handicapped people involved as well as those of the volunteers.

SG-06 Volunteers

SG-06.1 Agencies should recruit volunteers to support and supplement individual program plan-related activities.

SG-06.2 Agencies should have written statements of policy with respect to volunteers, including:

a) method of recruitment

b) criteria for selection

c) training

d) assignment

e) supervision

f) evaluation

g) recognition

h) termination of service.

Professional Support

Commentary

At any stage of the individual program planning process, team members may identify a client need for professional services or supports, such as audiology, nutrition, legal services, physical therapy, speech therapy, etc., to implement certain parts of the plan.

It is important that all individuals being served have access to the professional services/support they require to meet their needs. It is also important that the provision of such services/support be individualized, and not routinely and unnecessarily provided to a group of clients.

Professional services/support are most beneficial when delivered in an interdisciplinary manner, providing functional, developmental information for team members. Ideally, involved professional services should provide guidance and training to those working directly with the individual being served, so that relevant knowledge can be applied and used in the client's programs, routines and activities.

During the consultation process, service providers commented on the unavailability of professional supports in many communities. The Ministry recognizes this problem and hopes to work with service providers to develop services to meet these needs. The individual program planning process provides a framework for documenting gaps in resources. This information can be used as a basis for consultation with professionals and service organizations in the community, so that existing resources can be used effectively. It can also be used to assist the Ministry to identify needed resources.

SG-07 Professional Support

SG-07.1 Agencies should seek out needed professional support services in the community.

SG-07.2 When the supports required for an individual program plan are not readily available, agencies should identify service gaps in the community, and work with professionals and service organizations to develop the supports to fill these gaps.

Community Support

Commentary

Since the individual program planning process operates within the mainstream of community life, it is advantageous to receive support from the community. Community support is demonstrated in a number of ways, including both involvement of volunteers and contributions, financial and physical (for example, provision of facilities and materials). It provides important benefits for individuals with developmental handicaps, not only increased integration opportunities, but also establishment of arrangements with recreational and specialized professional services to ensure their availability and support.

To develop community support for individual program planning, it is helpful to begin by creating community awareness of the needs and rights of persons with developmental handicaps to participate actively in community life. This process entails both structured and informal communication with the public, developing a broad understanding of the principles of normalization and the developmental model, and encouraging community acceptance of people with developmental handicaps, as well as explaining the philosophy and goals of particular agencies.

SG-08 Community Support

SG-08.1 Agencies involved in individual program planning should collaborate to conduct public information and education activities, focussing on the needs and rights of people with developmental handicaps to participate in the mainstream of community life.

APPENDICES

APPENDIX A

THE INDIVIDUAL PROGRAM PLANNING PROCESS

SUMMARY OF THE INDIVIDUAL PROGRAM PLANNING PROCESS

	Stage of Process	Practical Considerations	Guiding Principles and Philosophies	Who	Refer to Guidelines
TG-01	Team Composition	Team may consist of one service provider and client/family/representative. Other members added as appropriate	Composition determined by need for service coordination, client wishes		TG-01.1
TG-02	Forming the Team Designate worker responsible, obtain written consent from client, determine potential team members and invite participation	Process of forming team may be informal or formal. Client consent to team membership, release of information needed.	Client participation in selection of team members	Agencies, worker(s) responsible, client/family/representative	TG-02.1 through TG-02.4
	Agency newly entering into helping relationship reviews existing plan, worker responsible joins team.	Within 30 days.	Team composition changes in response to client needs.	Agencies,worker(s) responsible, team	TG-02.5
TG-03	Selection of Coordinator Coordinator selected by the team	Any team member could be coordinator	Need for one person to take responsibility for overall coordination	Team	TG-03.1
TG-04	Responsibilities of Coordinator Convene and coordinate team meetings; monitor implementation; ensure work of team is documented, participate as team member.	Coordinator should be respected by other team members	Coordinator plays a facilitating role		TG-04.1

SUMMARY OF THE INDIVIDUAL PROGRAM PLANNING PROCESS (Cont'd)

	Stage of Process	Practical Considerations	Guiding Principles and Philosophies	Who	Refer to Guidelines
TG-05	Responsibilities of the Team Team responsible for development, implementation and review of plan	Responsibilities described in detail in other chapters	Team approach benefits clients and service providers		TG-05.1 through TG-05.4
AG-01	Role of Assessments Assessments to identify strengths, needs; to assist in developing training/ habilitation approaches; to monitor progress; to establish eligibility for services.		Assessments can serve many purposes but should contribute to individual program planning	Team	AG-01.1
AG-02	Identifying Assessment Needs Determine need for assessment as basis for a) placement b) planning, training or habilitation goals and approach	May be a: a) screening assessment b) functional assessment c) specialized assessment.	All information gathering efforts are aimed at maximizing the person's growth and quality of life, and consider both the person's achievements and his/her limitations.	I.P.P. Team members including client and family	AG-02.1
	Review need for further assessment with client and/or family and potential service providers	Domains from which needs may be identified include physical dev. and health; sensory motor dev. and skills; communication dev. and social skills; emotional and spiritual dev. independent living skills; ed./voc. skills; recreation & leisure; other domains as appropriate	Unnecessary repetition of assessments are avoided.	I.P.P. Team	AG-02.2

SUMMARY OF THE INDIVIDUAL PROGRAM PLANNING PROCESS (Cont'd)

	Stage of Process	Practical Considerations	Guiding Principles and Philosophies	Who	Refer to Guidelines
AG-03	Assessment Referrals Obtain written permission from client			I.P.P. Team	AG-03.1
	Prepare assessment referral	Person(s) assigned responsibility to make the referral could be the individual or his/her family	Usefulness of assessment results is increased when pertinent information accompanies an assessment referral	I.P.P. Team	AG-03.2 Appendix D
AG-04	Conducting Assessments Team members conducting assessments consider location, methodology		The assessment instrument and the person(s) chosen to do the assessment depend on the assessment needs identification. Assessments should include observation and testing in familiar environments, and focus on the person's adaptive behaviour. Instruments should be age and culture-appropriate to the individual.		AG-04.1 through AG-04.10
AG-05	Synthesis, Reporting & Follow-up of Assessment Team asks assessment service for written summary, assistance interpreting findings, assistance in implementing recommendation	Summary will include major findings re person's development, social network and physical environment, and identify strengths/needs.	Summary should be written in familiar, understandable language that answers the questions asked by the assessment referral. Follow-up should be provided to interpret the results or take action on recommendations.	I.P.P. Team	AG-05.1 through AG-05.3

SUMMARY OF THE INDIVIDUAL PROGRAM PLANNING PROCESS (Cont'd)

	Stage of Process	Practical Considerations	Guiding Principles and Philosophies	Who	Refer to Guidelines
DG-01	Development of the Individual Program Plan Develop I.P.P. within 30 working days after person's admission to service	If plan cannot be completed team establishes target date for completion. Parent and client are notified.	The person is viewed as an integrated or whole human being. The person has right to be part of decision making, and to be provided assistance to enable participation. An interdisciplinary team may be constituted for development of the plan.	I.P.P. Coordinator and team members including client, family, direct care staff.	DG-01.1 through DG-01.3
DG-02	Goal Planning Identify strengths and needs. Write measurable goals. State dates and means of implementation of top-priority goals.	Strengths are aspects of the person's life - skills, aptitudes, interests and relationships - that may enhance or facilitate development. Needs are areas where the person requires assistance, support or lacks behaviour or support needed to live in most independent manner. Strengths and needs are those identified in domains cited above through assessment. Team members are assigned responsibility for goal implementation and goal implementation review dates are identified.	Goals are based on an analysis of all observations and assessments. Decision involves judgement, and reflects personal and group values. Tone is always positive and client-centred. Programs emphasize skills and supports needed for success, rather than deficits or weaknesses. Priority should be given to goals leading to improved quality of life.	I.P.P. team members including client/ family	DG-02.1 DG-02.2

SUMMARY OF THE INDIVIDUAL PROGRAM PLANNING PROCESS (Cont'd)

	Stage of Process	Practical Considerations	Guiding Principles and Philosophies	Who	Refer to Guidelines
DG-03	Content of the Individual Program Plan Written plan identifies strengths, needs, goals, responsibilities, target dates. Contains signatures of team members	Team should select format appropriate for their needs	All important team decisions should be documented		DG-03.1 DG-03.2
IG-01	Implementation Plans State objectives, methods to achieve top-priority goals.	Objectives of an implementation plan are precise statements of program outcome, and must be measurable. Methods to meet objectives must be stated. Detail methodology for accompanying each objective. Specify dates for commencement, review, projected completion.	The implementation plan should be appropriate to the nature of the goal and the characteristics and style of the client, and should reflect the foundation principles and philosophies. The methodology should utilize generic resources as much as possible.	Team members, (staff, client, family) assigned responsibility to meet each of top-priority goals	IG-01.1 through IG-01.5
IG-02	Monitoring Team members inform coordinator about progress, difficulties. Coordinator consults with team members	Frequent contact between coordinator, team members encouraged. Existing channels can be used to resolve difficulties	Monitoring needed to ensure plan implementation	I.P.P. Coordinator and team	IG-02.1 IG-02.2

SUMMARY OF THE INDIVIDUAL PROGRAM PLANNING PROCESS (Cont'd)

	Stage of Process	Practical Considerations	Guiding Principles and Philosophies	Who	Refer to Guidelines
RG-01	Review of Individual Program Plan Review plan at least once a year	Should be based on objective information about progress. Can lead to new goals, methods, responsibilities	Review process allows for change to occur if implementation targets are not realized. Provides a feedback loop to team re the effect of the implementation	I.P.P. Coordinator and team	RG-01.1 RG-01.2
FG-01	Content of Records I.P.P. file for client should contain copies of I.P.P.'s, implementation plan(s), legal documents, other relevant information	Revision of goals and implementation plan are based on the evaluation of the written outcomes.			FG-01.1
FG-02	Maintenance of Records One member maintains I.P.P. file; other members have copies of I.P.P.	Team selects member to maintain file.		Team	FG-02.1 FG-02.2
FG-03	Access & Disclosure Secure I.P.P. file against access by unauthorized persons, loss or destruction.	Consents are obtained from client/family prior to release of information to persons other than I.P.P. team members.	The right of the client to personal privacy must be safeguarded while access to adequate client information is provided for service providers. The client and/or his/her family should have access to the I.P.P. file.	Team	FG-03.1 FG-03.2

APPENDIX B

GLOSSARY OF TERMS

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GLOSSARY OF TERMS

Adaptive Behaviour - The effectiveness or degree with which an individual meets the standards of personal independence and social responsibility expected of his or her age and cultural group.

Assessment - See Diagnostic Assessment, Functional Assessment.

Capacity - As defined in Bill 77, An Act respecting the Protection and Well-being of Children and their Families, "capacity" means the capacity to understand and appreciate the nature of a consent and the consequences of giving, withholding or revoking the consent.

Case Manager - A person who assists another individual with information, referral and follow along services, and may function as an advocate when there are barriers to needed services.

Client - Any developmentally handicapped person for whom services are being sought or provided.

Consent - As defined in Bill 77, An Act respecting the Protection and Well-being of Children and their Families, a person's consent or revocation of a consent is valid if, at the time the consent is given or revoked, the person:

a) has capacity;

b) is reasonably informed as to the nature and consequences of the consent, and of alternatives to it;

c) gives or revokes the consent, without undue coercion or undue influence; and

d) has had a reasonable opportunity to obtain independent advice.

Consent (cont'd) — A person's nearest relative (that is, a person with lawful custody when the person is a child or as defined in The Mental Health Act, when the person is not a child) may give or revoke consent on the person's behalf if it has been determined on the basis of an assessment, not more than two years before the nearest relative acts on the person's behalf, that the person does not have capacity.

Coordination - The process of arranging necessary resources in the appropriate sequence to accomplish a given objective. Coordination involves initiating, sustaining, and interrelating the various parts of the service delivery system.

Criterion-Referenced Test - An assessment tool that evaluates individual performance in relation to a fixed standard: the person is evaluated against himself/herself. It produces standards or reference points that are fixed at specific cut-off points, and do not depend on a referenced group. It applies directly to individual instruction since the test is directly referenced to objectives of instruction. It is a formative evaluation tool, and may also be used as a summative evaluation tool.

Developmental Model - A principle for human service that requires agencies to provide or obtain a continuum of programs for developmentally handicapped individuals in accordance with their needs. It is based on the assumption that development is lifelong, and proceeds in a sequential, orderly and predictable manner, but with varying rates and directions that can be influenced by an individual's environment.

Developmental Needs - Those needs associated with substantial functional limitations in any facet of a person's development, including physical, sensorimotor, communication, and social/emotional domains as well as those aspects of behaviour that are adaptive: i.e. self-care, independent living and vocational skills.

Developmental Handicap - A condition of mental impairment present or occurring during the formative years that is associated with limitations in adaptive behaviour.

Diagnostic Assessment - Direct observation that determines whether, and to what degree, an individual has developmental deficits, for the purpose of devising an individualized program of action to enable the individual to move towards increasingly independent functioning. The assessment identifies the individual's present developmental level; the individual's abilities, strengths and developmental needs; the conditions that impede the individual's development; and, where possible, the cause of the disability.

Evaluation - The process of determining whether stated goals and objectives have been accomplished. A complete program evaluation includes:

- o examination of adherence to basic principles of service delivery
- o review of the effectiveness of operations, including management and staffing practices, use of financial and material resources, use of staff and so on
- o review of program quality that examines adherence to professional and program standards of service delivery
- o assessment of the program's success in setting and meeting goals, in other words a review of outcome
- o measurements of cost-effectiveness and efficiency.

Functional Assessment - Direct observation that yields a clear and complete profile of an individual's competencies, and assists in identifying learning targets to be established or improved. It is usually based on a developmental sequence, and it leads directly to an objective, systematic program plan.

Goal - A statement of relatively broad scope that describes the outcome or conditions expected as a result of intervention. It guides the establishment and sequencing of short-term or intermediate objectives directed towards its attainment.

Habilitation - The process by which the staff of an agency assists an individual to acquire and maintain those life skills that enable the individual to cope more effectively with the demands of his or her own person and environment, and that raise the level of his or her physical, mental and social functioning.

Individual Implementation Plan - A component of an overall individual program plan which documents in written form specific objectives related to overall goals, the methods used to accomplish these and the approach used to monitor or evaluate the client's progress.

Individual Program Planning - The process of planning a coordinated service that is designed to enhance the development of an individual who is developmentally handicapped. This service includes the assessment of the individual, the development of written plans comprising long term goals and short-term objectives for the individual, the implementation and coordination of these plans, and the monitoring and evaluation of the plans.

Individual Program Plan - A written plan for action that is developed on the basis of assessment results and modified at frequent intervals with the participation of all concerned. It specifies goals and objectives, and identifies a continuum of development, outlining projected progressive steps and the developmental consequences of services.

Individual Program Plan Coordinator - The person on the individual program plan team who, in cooperation with the team, is responsible for ensuring that the client's individual program plan is developed, implemented and reviewed as scheduled. If the client has a case manager, this person may serve as the individual program plan coordinator.

Integration - A set of physical circumstances and social processes enabling a handicapped person to participate in patterns and conditions of everyday life that are as close as possible to the norms of the mainstream of society.

Interdisciplinary Team - An approach to individual program planning in which professionals, other personnel, the individual being served and the individual's family or advocate participate as a team. Each participant, utilizing the skills, competencies, insights and perspectives his or her training and experience provide, focusses on identifying the strengths and needs of the individual, defining goals and devising ways to meet them, without the constraints imposed by assigning particular domains of behaviour to particular disciplines only. Participants share all information and recommendations, and develop as a team a single individualized plan to meet the individual's identified needs.

Least Restrictive Alternative - The intervention into the life of a developmentally handicapped individual that is the least intrusive into, and least disruptive of, the individual's life, and that represents the least departure from normal patterns of living that can be effective in meeting the individual's developmental needs.

Monitoring - A process for measuring the extent to which an individual service provider, a service agency or a service system is delivering services in accordance with professional, governmental or other generally accepted standards and/or guidelines. Monitoring addresses itself to the processes and conditions of service delivery, rather than to goal attainment.

Nearest Relative - As defined by The Mental Health Act, "nearest relative" means:

a) the spouse who is of any age and mentally competent; or

b) if none or if the spouse is not available, any one of the children who has attained the age of majority and is mentally competent; or

c) if none or if none is available, either of the parents who is mentally competent or the guardian; or

d) if none or if neither is available, any one of the brothers or sisters who has attained age of majority and is mentally competent; or

e) if none or if none is available, any other of the next of kin who has attained the age of majority and is mentally competent.

Needs - Areas where an individual requires intervention to establish a skill, increase the level of skill competency, or alter the frequency of a given behaviour. Needs constitute potential program goals that can be sequenced developmentally.

Norm-Referenced Test - An assessment tool that evaluates individual performance in comparison with a group of persons. It produces standards or reference points that are average, relative points derived from the performance of a group used for norming. It is designed to maximize variability, and produce scores that are normally distributed. It is more a summative tool than a formative tool, and applies poorly to individual instruction.

Normalization - The use of culturally normative means to offer developmentally handicapped persons life conditions at least as good as those of average citizens and to as much as possible enhance or support their behaviour, appearances, experiences, status and reputation.

Objective - A learner-oriented statement that describes in behavioural and measurable terms the outcome of intervention. It specifies the behaviour, conditions under which it will occur, degree of success and, usually, the timeframe (short term or intermediate).

Outcome - The extent to which the goals of an individual, a program, an organization or a service delivery system have been achieved.

Program - A structured set of activities to achieve specific objectives relative to the developmental needs of the individual served by an agency. The basic goal of programming for developmentally handicapped persons is to maximize the individual's personal, social and vocational development.

Inter-rater Reliability - The extent to which two or more persons, rating the behaviours or characteristics of an individual, group of individuals or an organization agree on the score to be awarded.

Test-retest Reliability - The extent to which repeated measures of a behaviour or characteristic using the same instrument will yield the same score.

Representative - A person who assists the client to present his or her views to the individual program plan team

Service - The totality of programs provided by an agency or organization.

Service Providing Agency - An agency that provides human services to groups and individuals.

Strengths - Positive characteristics and conditions that may facilitate an individual's development. These include: areas in which the individual shows competency; behaviours that may serve as prerequisites for more complex skills; personal characteristics that enhance interpersonal relationships; the individual's interests and preferences; significant persons who may facilitate development.

APPENDIX C

DOMAINS TO BE CONSIDERED IN THE INDIVIDUAL PROGRAM PLAN

APPENDIX C

DOMAINS TO BE CONSIDERED IN THE INDIVIDUAL PROGRAM PLAN

Physical development and health: The physical development and health needs of developmentally handicapped individuals include all aspects of health care, both physical and mental, required by all persons, as well as any special needs or aids associated with the specific developmental handicap. Regular preventive and remedial health care is essential in maintaining optimal health, which enhances development in all other areas.

The individual program plan should describe plans for the delivery of general health assistance in the following areas as required:

1. preventive health services, which include:
   - immunization and the prevention of communicable diseases
   - dental care, including daily care, periodic dental examinations, provision of oral prophylaxis

2. detection, diagnosis and treatment of sensorimotor devices (for example, in vision, hearing)

3. provision, of corrective, orthotic and prosthetic devices in accordance with specialists' recommendations, accompanied by:
   - periodic reevaluation of devices by appropriate professionals, to ascertain continued applicability and fitness, and to recommend changes as needed
   - instruction to handicapped individuals and caregivers in proper use and care of devices

4. specialized health services, which include:
   - specialized medical treatment
   - dental treatment as indicated
   - sex education
   - in-home health services
   - family planning
   - genetic counselling
   - diagnosis and treatment of seizure disorders
   - psychiatric treatment or counselling

5. nutrition, including adequate and appropriate diet, mode and circumstances of eating, and maintenance of acceptable weight

6. personal hygiene and provision for privacy of care

7. administration or self-administration of medication, to be monitored and reviewed by authorized persons for medication errors, drug reactions and long-term effects

8. detection and treatment of injury, disease and abuse, either physical or psychological

9. formulation of and education about emergency procedures

10. access to community health programs and professionals.

Sensorimotor development and skills: The individual's opportunities for development and participation in normal everyday activities are enhanced with increasing skill in and integration of the sensorimotor functions. These include control and coordination of the movement of eyes, hands, arms, legs and body, enabling the handicapped individual to have some functional interaction with his or her environment. Also included are balance, dexterity, mobility (ambulatory and non-ambulatory) and the use of information from the senses -sight, sound, touch, smell, and taste.

The individual program plan should describe plans for the delivery of assistance in the following areas as required:

1. detection and treatment of sensorimotor handicaps

2. training or assistance as appropriate in motor and perceptual skills, including but not limited to:

   - visual attention and discrimination
   - auditory attention and discrimination
   - tactile discrimination
   - reaching, grasping, releasing and using hands for living skills, tool use, eye-hand coordination (including catching and throwing) and eye-foot coordination (kicking)
   - balance, posture, rhythm, dexterity
   - locomotion (rolling, crawling, creeping, walking, running, climbing, jumping, riding equipment)

- body awareness

- movement of body parts (knee/arm flexion-extension, leg, neck, shoulders, wrist, arm, ankle, foot, finger) in isolation, through space and in functional activity

Communication development and social skills: The sharing of ideas and feelings that form the bonds of interpersonal relations can be accomplished through verbal and/or non-verbal means. The facilitation of language development is founded on the experience of and opportunity for communication. Communication in turn affects the individual's ability to interact with and relate to his other family and other people in his or her social network. To have something about which to communicate requires a life rich in experiences.

The individual program plan should describe plans for the delivery of assistance in the following areas as required:

1. training and assistance aimed at fostering language development, which includes:

   - comprehending language, evidenced through appropriate responses and following directions

   - using language, verbal or manual including gesture, symbol and sign communication, to express wants, needs, and ideas, and to initiate and respond to social interaction

   - an environment that supports development by providing the opportunity to communicate, people to communicate with and something to communicate about

2. training and/or assistance in using various communication modes for speaking, reading and writing, which depends on:

   - availability and utilization of communication media in common use including the telephone, letters, books, newspapers, and magazines

   - radio, television, films, tape recordings, record players and other specialized equipment as may be required

3. training or assistance as appropriate in the establishment or maintenance of interpersonal and social skills and characteristics, including but not limited to:

- sharing, cooperation, courtesy
- responsibility, law-abiding behaviour
- social etiquette appropriate to age and culture
- positive and realistic self-concept
- age- and culture-appropriate expression of emotions

Emotional and spiritual development: The development of a positive, realistic self-concept and emotional maturity influences/and is influenced by inter-personal relationships. Belonging, friendship, loving and being loved form part of the essential nature of all persons.

The individual program plan should describe plans for the delivery of assistance in the following areas as required:

1. provision for continuity, consistency and security in relationships and living arrangements
2. protection of privacy (in living space, possessions, correspondence)
3. ownership (personal belongings and permission to decorate private space in an alterable manner)
4. opportunity for and participation in decision making pertaining to all aspects of life as appropriate to age and ability
5. fostering of curiosity, initiative, enthusiasm
6. opportunity for aesthetic appreciation and religious experience and affiliation in accordance with personal preference or guardian's wish
7. self-expression and creativity through age- and culture-appropriate means (language, art).

Independent living skills: Growth in personal management and community living skills contributes to the dignity and independence of the handicapped person's life. Personal management skills include self and health care, food handling and preparation, household care and maintenance, and all other knowledge and skills or support that enable personal autonomy. Most people's lives are characteristized by some interaction with their community. Being able to use transit, locate services, and be a consumer enhances the degree and quality of the inividual's community life.

The individual program plan should describe plans for the delivery of assistance in the following areas as required:

1. training or assistance as appropriate in self and health care, including, but not limited, to the following:

   - eating and drinking (including method, circumstances, etiquette, use of adaptive equipment, shopping, meal planning and preparation, food handling and storage)
   - toileting (including independence, privacy, dignity, and etiquette)
   - personal hygiene (including washing, bathing, shampooing, brushing teeth and feminine care)
   - dressing (including ownership, selection, coordination, purchasing and care of clothing)
   - grooming (including shaving and hair and nail care)
   - health care (including nutrition, medication, first aid, special aids and equipment, preventive health care and safety)
   - home management (including meal preparation, cleaning, clothes washing and use of housekeeping equipment)
   - financial management (including possession of personal funds, money handling, purchasing, budgeting, saving, banking, consumer knowledge)

2. provision of services and equipment necessary to increase mobility or movement in the living, working, learning and community environments, including:

   - instruction for handicapped individual and caregivers in the safe use and care of mobility devices and procedures
   - promotion of the establishment of and training in the use of generic community transportation services that are usable by handicapped individuals
   - securing transportation enabling access to programs and services throughout entire week
   - provision of driver education to persons capable of learning to drive

3. maximization of access to and optimal use of buildings requiring adaptation to accommodate physical handicaps

4. access to generic community services and resources.

Education/vocational skills: Learning and working are central to the lives of most people. The acquisition of knowledge and skills for thinking and learning is life-long and at certain times in the life cycle directed towards vocational activity. The opportunity to prepare for and engage in work and employment adds a new dimension to the life of the handicapped individual. Academic and vocational instruction should be commensurate with individual ability and potential, and should reflect the realistic aspirations of handicapped persons and their families or advocates.

The individual program plan should describe plans for the delivery of assistance in the following areas as required:

1. training, assistance and environmental support as appropriate in the development of pre-academic and academic skills, including but not limited to:

   - specific concepts (object, body, colour, shape, size, weight, volume, time, space, number)

   - process (visual and auditory attention, discrimination and memory, causality, means/end, categorizing)

2. maximization of prerequisites for learning including attention, initiation, memory

3. assurance that learning progresses from skill acquisition to functional utilization

4. training in problem-solving and decision-making strategies with opportunities to experience consequences of decisions

5. training and assistance as appropriate in preparing for and securing vocational activity, either sheltered or competitive employment, including but not limited to:

   a) orientation to work and employment

      - purpose and value of work

      - characteristics of work environments

- job opportunities, availability and risks
- wage expectations and fringe benefits
- employee organizations and work-related activities
- grievance and separation procedures

b) work evaluation and assessment to:

- determine work interests
- measure general and specific work abilities
- measure task performance and proficiency levels
- assess attitudes and adaptability needed for employment

c) participation in training that:

- reflects current and relevant activities in the labour market
- provides therapeutic benefits to the individual's development
- develop skills specific to identified jobs
- develops appropriate attitudes and habits of work, dress and hygiene for job adjustment as well as job-seeking skills
- maximizes job placement with on-the-job training when possible
- incorporates necessary and appropriate communication procedures, mobility requirements and interpersonal work relationships, as well as preparation for adaptation to change in work or employment conditions and responsibilities

Recreation/Leisure: Recreation and leisure activities make free time enjoyable and satisfying, and provide natural opportunities for self-expression, social interaction and emotional growth. Recreation and leisure activities may be planned for the handicapped person or eventually be self-initiated, and help to ensure personal and community integration.

The individual program plan should describe plans for the delivery of assistance in the following areas as required:

1. training, assistance and opportunity for participating in recreation and leisure time activities

2. planning and organization for recreation and leisure, including:

   - consideration of accessibility to and ability to use transportation
   - consideration of availability and handling of monies needed
   - opportunities to participate with non-disabled people and persons of both sexes

3. recreation and leisure activities chosen with consideration for:

   - development of group and individual leisure skills
   - development of social interaction skills with both sexes, of all ages
   - development and maintenance of physical and mental health
   - grouping of the individual according to his/her abilities and expressed wishes

4. activities selected as appropriate for daytime, after school, after work, weekends, changing seasons and vacations

5. activities consistent with those available to all communty members and, with adaptations as necessary, including:

   - excursions, outings and trips to community facilities
   - hobbies, collections, clubs, special interest and discussion groups, spectator activities, games, parties and celebrations of special events
   - individual, dual and team sports activities; physical fitness and aquatic activities
   - outdoor and nature activities including camping, hiking, gardening and winter activities
   - simple to complex fine arts activities including music, drama, dance, painting and sculpture as well as crafts
   - service clubs and organizations
   - activities of the individual's own choosing.

APPENDIX D

OUTLINE FOR ASSESSMENT REFERRAL

APPENDIX D

OUTLINE FOR ASSESSMENT REFERRAL

SECTION	CONTENTS
Identifying Data	
"This is the individual"	Name, age, address, legal status, school and grade or vocational placement.
"This is how the individual was brought for help"	Names of those persons involved in the referral process.
Presenting Problem	
"This is why the individual was referred"	A list of the issues of primary concern, usually behavioural observations.
History of Current Difficulties	
"This is what has been happening in the individual's life recently and has led to this referral"	Description of problems, duration. How they were noticed and for whom they create difficulties. What precipitates them, where; when. What makes them better or worse. How the individual, his or her family and service providers explain causes. What attempts have been made to help.
Purpose of Assessment	
"This is why we need assessment information"	To establish the existence and extent of delay. To establish eligibility for service. To make or change service placement decisions. To develop or change a detailed training or habilitation program for the individual.

Information Required

"These are the questions we want the assesment to answer"

What are the individual's specific abilities? (For example: Can this person hear a conversation spoken in a normal tone of voice? Can this person pick up a 1/2" bolt?)

What are the individual's strengths? (For example: What does this person like? What does this person do well?)

What are the individual's weaknesses? (For example: What does this person dislike? What does this person not do well?) What factors, including social and environmental factors, affect this person's behaviour? (For example: Why is this person always late for work? Why does this person have difficulty recognizing colours?)

What should be the short and long-term goals for this person? What can be done to help this person achieve these goals?

APPENDIX E

SAMPLE INDIVIDUAL PROGRAM PLAN

FORMATS

This Appendix provides two sample formats for the development of Individual Program Plans. Appendix F provides sample formats for the implementation component of the IPP.

INDIVIDUAL PROGRAM PLAN

FOR: (Name of Client)

Dev./ Service Area	Strengths	Needs	Statement of Overall Goal	Priority	Implementation	Date to Start & Complete	Person/ Service Responsible	IPP Review Date	Monitoring/Evaluation/ Progress/Follow-up
					(How goal is to be achieved - may include eqiuipment and other pre-requisites)				

Signature of all Team Members:

Date:

IPP TEAM INFORMATION

IPP For: (Name of Client)

Team Members:	Role: (co-ordinator, parent, program staff, etc.)

Date(s) of Meeting:	Location:	Comments:

Information Presented:
(previous IPP, assessments, etc.)

Information to be Gathered:
(referrals, consultations, follow-up, etc.)

Persons/Agencies Providing Service/Support
(includes family, volunteers, generic services, special services, etc.)

Agency/Service Needs:
(equipment, arrangements, barriers, etc.)

INDIVIDUAL PROGRAM PLAN

INITIAL____REVISION____#

NAME:

D.O.B.

ADDRESS:

DATE OF TEAM MEETING: _____ LOCATION: _____

TEAM LEADER _____

ASSESSMENTS/CONSULTATIONS

TYPE	DATE	COMPLETED BY:

RECOM. FOR FURTHER ASSMT/CONSULTATION	TO FOLLOW-UP	DATE COMPLETED

TEAM PARTICIPANTS:
NAME/POSITION/RELATIONSHIP TO CONSUMER/CLIENT

SIGNATURE

1.

2.

3.

4.

DEVELOPMENTAL DOMAINS	STRENGTHS	NEEDS	OVERALL GOALS	PRIORITY	GENERAL PLAN OF IMPLEMENT-	RESPONSIBILITY	DATES BEGIN REVIEW COMPLETED
PHYSICAL DEVELOPMENT AND HEALTH							
SENSORIMOTOR SKILLS AND DEVELOPMENT							
COMMUNICATION SKILLS AND DEVELOPMENT							

SOCIAL SKILLS
AND EMOTIONAL
DEVELOPMENT

INDEPENDENT
LIVING SKILLS

EDUCATIONAL/
VOCATIONAL
SKILLS

RECREATION/
LEISURE

COMMENTS/EXPLANATIONS/FOLLOW-UP

Implementation Plans

APPENDIX F

SAMPLE FORMATS FOR IMPLEMENTATION PLANS

This Appendix provides three sample formats for the implementation of the goals set out in the Individual Program Plan. The implementation component of the individual program plan is often called an individual training plan (ITP), habilitation plan, (IHP), educational plan (IEP), or infant development plan (IDP).

IMPLEMENTATION PLAN
STATEMENT OF GOAL: (from I.P.P.)

POR: (Name of Client)

Short-Term Objective	Method of Implementation	Method of Evaluation	Person/ Service Responsible	Resources	Location	Progress/Results/ Follow-up

Signatures of Implementors:

Date Started:
Review Dates:

Date Completed:

TEACHING/TRAINING PLAN

DEVELOPMENTAL AREA: _____ PRIORITY GOAL NO. _____

NAME: _____ PERSON(S) RESPONSIBLE: _____

INDIVIDUAL PROGRAM PLAN COORDINATOR: _____

LONG RANGE GOAL: _____

PRE-REQUISITE/ TOOL SKILLS	DATE PROGRAM STARTED	DATE OBJECTIVE ACHIEVED	SHORT TERM OBJECTIVES	BARRIERS TO MEETING SHORT TERM OBJECTIVES

ENVIRONMENTAL OPTIONS	METHODS INSTRUCTION	CONSEQUENCES OF ACHIEVING SHORT TERM OBJECTIVES	CONSEQUENCES DESIGNED TO ELIMINATE/ REDUCE BARRIER
1) WHERE			
2) WHO ELSE			
3) HOW LONG			
4) WHEN			
5) MATERIAL & EQUIPMENT			
6) PRACTICE SESSION			

INDIVIDUAL TRAINING PLAN

NAME: DATE PROGRAM BEGUN:

TEACHER: REVIEWED:

ADVISOR: COMPLETED:

DEVELOPMENT AREA

OVERALL GOAL:

PRESENT BEHAVIOUR:

IMMEDIATE OBJECTIVE:

PROCESS

- who, where, when, how long
- materials needed
- training method
- kind and schedule of reinforcement

EVALUATION

- what to observe and how & where to record it
- aim or criteria
- when and how to change program; next stage

APPENDIX G

SAMPLE SUMMARY FORMAT:

INDIVIDUAL CLIENT SUMMARY

SAMPLE FORMAT SUMMARIZING

THE OUTCOMES OF INDIVIDUAL PROGRAM PLAN REVIEWS

FOR EACH DEVELOPMENTALLY HANDICAPPED PERSON BEING SERVED

Name of Client/Consumer: Tim Jackson

Date of Entry into Service: January 1, 1984

Name of Facilitator: Sue Wood

Dates of Individual Program Plan Reviews:

Objectives	March 1/84	July 1/84
1. Tim will tie his shoelace with no assistance on 3 consecutive trials	0	
2. Tim will place a phone call on office telephone, given verbal cues, on 4 trials.	/	0
3.		
4.		

KEY: 0 = objective met
/ = progress towards objective
X = no progress
C = program change
T = program terminated

APPENDIX H

SAMPLE INDIVIDUAL PROGRAM PLANNING SCHEDULE

SAMPLE SCHEDULE

SHOWING INDIVIDUAL PROGRAM PLAN -

RELATED EVENTS FOR ALL DEVELOPMENTALLY HANDICAPPED PERSONS

BEING SERVED

YEAR: 1984

Client/Consumers' Names	Facilitators' Names	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.
Mary Smith	Jack Jones		A	C				R				R	
Tim Jackson	Sue Wood		R			A	C				R		

KEY: A = Assessment

C = Individual program plan team conference

R = Internal individual program plan review

APPENDIX I

BIBLIOGRAPHY

APPENDIX I

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